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The
**ROYAL CANADIAN
DENTAL CORPS**
Quarterly

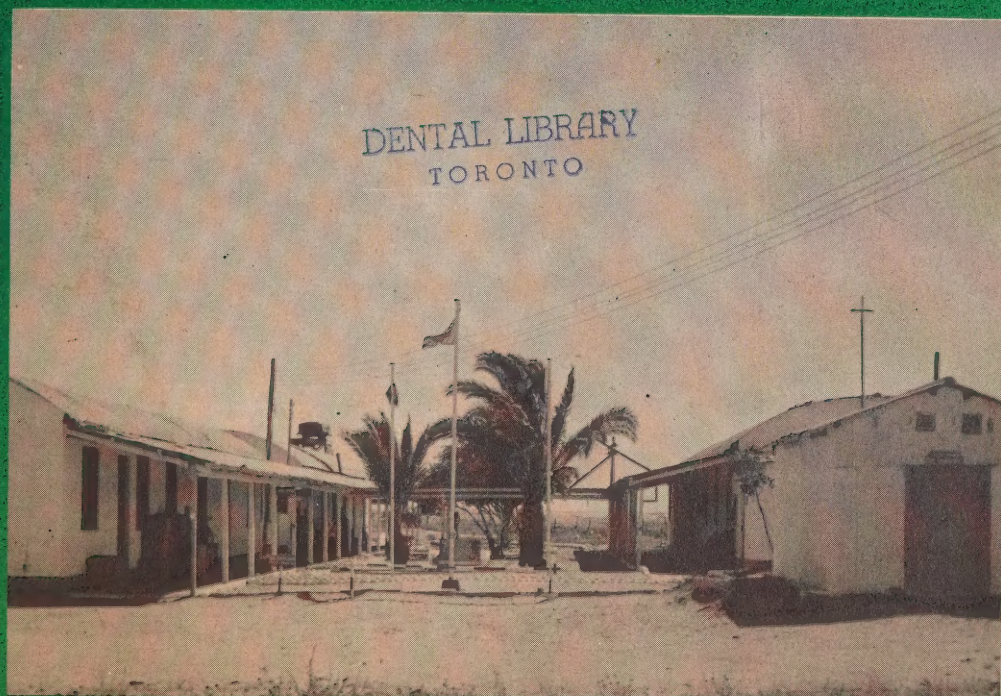


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THE RCDC QUARTERLY

Published by authority of Brigadier KM Baird, Director
General of Dental Services for the Canadian Forces

Editorial Board: Col GB Shillington
Lt Col GR Covey
Lt Col DH Hillier

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SUBSCRIPTION RATES

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E D I T O R I A L

The Monthly Letter of November 1961 published by The Royal Bank of Canada has this to say about time:

"Time is the raw material of life. Every day unwraps itself like a gift, bringing us the opportunity to spin a fabric of health, pleasure, and content, and to evolve into something better than we are at its beginning."

The gift of time brings no magic with it. It is only made available. We must study how to get the most out of the passing days."

"This learning is an individual thing, but there are some basic tools and ideas of management that can help us. Here are three undeniable facts: (1) Time can be measured, therefore apportioned; (2) time is always passing, and it never returns; (3) time can be wasted, just as we waste materials, money and energy."

"To us as individuals time is the essence of our being; to the clock it is a measured interval; to the nurse it is a pulse record; to the engineer of conservation dams it is a sedimentation rate. A philosopher may think of it as the past increasing by diminution of the future."

A dentist may think of time in relation to the various operations to be performed for his patients, how many patients he can accommodate in his working day and the productivity achieved in his office over a given period. He may consider that, in his busy practice, he has reached his maximum productivity, yet motion and time studies might reveal otherwise. Incomplete utilization of his auxiliary's services and wasted motion through poor location of his equipment can rob him of considerable time and energy.

The dental assistant should function as an additional pair of hands for the dentist but, to act in this capacity, must be beside the chair helping in every possible manner for as long as required. The position of equipment, instruments and supplies is of paramount importance in reducing waste motion. Why should it be necessary for the assistant to walk around the chair to the cabinet to mix cement when materials and a table for this purpose can be close at hand? Or why should the dentist turn around to obtain an instrument in the cabinet when with a little planning it can be made available on a tray close by?

A re-organization in some dental offices undoubtedly would lead to greater productivity and far less fatigue for both dentist and assistant. Motion and time studies have produced remarkable results in industry and there is every reason to believe that a broad, new vision of dental practice is being unfolded through application of similar studies in the dental office. An extension of the services that can be rendered by trained auxiliaries would complement this picture and will require considerable investigation. In the latter instance, the RCDC has already conducted one study and confidently expects to play its part in developing methods for, and promoting the more efficient use of time and energy in dental practice.

CANADIAN DENTAL DETACHMENT
CANADIAN BASE UNITS MIDDLE EAST

Major EJ Small CD BA BSc DDS

Since the Canadian Dental Detachment CBUME is part of the United Nations Emergency Force stationed in the Gaza Strip, it may be pertinent to recapitulate the series of events which led to the formation of UNEF itself.

PALESTINE

Palestine is a narrow strip of land on the extreme eastern shore of the Mediterranean Sea, bounded from north to south by Lebanon, Syria, Jordan and Egypt. In the southwest it is separated from the sea by a finger-like projection thirty miles long by five miles wide under Egyptian administration known as the Gaza Strip.

Before World War I Palestine contained both Jewish and Arab settlements as well as wandering Bedouin tribes, and was part of the Ottoman (Turkish) Empire. After the defeat of Germany and its satellites by the Allies, The League of Nations granted Great Britain a mandate to govern and administer the territory. One of the terms of the mandate was the implementation of the "Balfour Agreement", the main tenet of which was the establishment of a national home for the Jews in Palestine, with a guarantee of civil and religious rights for the non-Jewish communities.

Throughout the years there had always been some immigration of European Jews to Palestine, but since the late thirties and especially after World War II this immigration increased tremendously, and was followed by disturbances between the Arab and Jewish populations.

As more Jewish immigrants poured in conditions worsened, and as a result of charges and counter-charges between the Jewish Agency for Palestine and the Arab Higher Committee, a United Nations Committee was formed for the purpose of investigating and reporting on all matters which in its opinion would lead to peace in the area.

PARTITION PLAN

As a result of the findings of this committee the UN General Assembly adopted the Partition Plan, one of three plans for the attainment of peace. This plan called for the division of Palestine into an Arab state and a Jewish state, the withdrawal of the British Armed Forces, and the termination of the British mandate.

Representatives of all Arab states in the UN denounced the plan, and stated that not only would they resist partition, but would refuse to recognize the UN resolution in this respect.

On 14 May 1948 Great Britain withdrew her troops, relinquished her mandate, and a Jewish state was proclaimed under the name of Israel.

OUTBREAK OF HOSTILITIES

The next day the Arab states instituted armed action in Palestine, and fighting continued until 18 July, when the Security Council of the UN succeeded in bringing about a cease-fire. This proved to be but a temporary respite, and

large-scale fighting broke out again between the Israelis and Egyptians in the Negev. The Security Council repeatedly called for a truce, and finally succeeded in arranging a General Armistice Agreement between Israel and Egypt on 24 Feb 1949, soon followed by further armistice agreements with Lebanon, Jordan, and Syria.

Unfortunately the Armistice Agreement was followed by border incidents which rapidly increased in severity and numbers, culminating in October 1956 with a full-scale invasion of the Sinai by Israeli troops.

FORMATION OF UNEF

As a result of military action by French and British troops, the UN General Assembly held a meeting and adopted a proposal put forward jointly by Canada, Columbia and Norway calling for an emergency international force to secure and supervise the cessation of hostilities between Egypt and Israel. This resolution also appointed "on an emergency basis" the Chief of Staff of the UN Truce Supervisory Organization, Major-General ELM Burns, as Chief of the Command.



The Sinai Peninsula

On 15 Nov 1956 the first UNEF troops, a Danish unit, arrived in Abu Suweir, near Ismailia, and were soon followed by Columbians, Yugoslavs, Indians, Swedes and Canadians.

As Israeli forces withdrew, the main body of UN troops took up positions in all centers of population and camps in the Gaza Strip. HQ UNEF was set up in the town of Gaza, and reconnaissance units deployed along the Israeli-Egyptian frontier from Rafah to the Gulf of Aqaba.

PALESTINIAN REFUGEES

Apart from the question of territorial modifications, relations between Egypt and Israel are aggravated by the problem of the Palestinian refugees. There are some 260,000 of these refugees in the Gaza Strip alone, and the question of their disposal has lead to sharply opposing views between the Arab states and Israel. The former affirm that Israel refuses to comply with UN General Assembly resolutions according to which, they hold, the refugees can choose between repatriation and compensation. Furthermore, they say, until this right of choice is admitted by Israel it will be impossible to implement other resolutions calling for the absorption of the refugees and their integration into the economic life of the Middle East.

Israel's stand is that the refugees were created by the Arab states as a direct result of their military action against Israel in 1948, and that for internal security and political stability the refugees cannot be re-admitted to the present state of Israel. In addition, they argue that the best interests of both the refugees and the Arab states themselves would be served by their relocation in the Arab states. Israel has expressed its willingness to discuss the question of compensation.

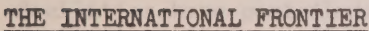
In the meantime the refugees are assisted by the free provision of food, shelter and clothing by the United Nations Relief and Works Agency (UNRWA), which is attempting also to rehabilitate and educate them.

THE GAZA STRIP AND THE ADL

The General Armistice Agreement between Egypt and Israel fixes the boundary between Israel and the Gaza Strip by a line known as the Armistice Demarcation Line or ADL. For the most part the ADL takes the form of a three-foot ditch. Along its 35 miles are 73 UNEF observation posts which are manned during daylight by two soldiers with binoculars. At night, patrols move by foot along their sector of the ADL keeping in contact with their units by two-way radio.

In order to limit unauthorized crossings of the ADL, a regulation is in force restricting the movements of inhabitants of the Strip to a distance of 500 meters from the ADL by night and 50 meters by day. If they are working the land, they may work right up to the line.

The Gaza Strip itself covers an area of 200 square miles, running in a NE - SW direction from the town of Gaza to Rafah. Within it are troops of the various national contingents of UNEF with the exception of the Yugoslav Reconnaissance Battalion which is stationed at El Arish, about three miles from 115 ATU RCAF. Component troops have been allotted certain areas for which they are responsible. The Swedish Bn is entrusted with the task of guarding HQ UNEF, Gaza, and a small portion of the ADL. The Danor (mixed Danish and Norwegian) Bn is responsible for some eleven miles of the ADL from the Mediterranean Sea to the



The International Frontier, or IF, begins on the Mediterranean Sea and for the first seven miles it separates Egypt from the Gaza Strip. Subsequently, it passes through Rafah, joins the ADL and continues straight through for almost 120 miles to the Gulf of Aqaba, forming a boundary between Israel and the Negev on the one side, and Egypt and the Sinai on the other.

The northern sector of the IF is guarded by the Canadian Reconnaissance Squadron with Headquarters in Camp Rafah and two outposts twenty-five miles apart on the IF. From these three locations mobile patrols are sent out daily at irregular intervals, the sensitive areas being patrolled by ground patrols, the other sectors by air reconnaissance from 115 ATU RCAF. The southern sector is the responsibility of the Yugoslav Reconnaissance Bn.

Camp Rafah is situated near the junction of the ADL and the IF and covers an area of 260 acres of flat sandy desert dotted by whitewashed buildings. The outstanding feature of the area is an ochre-coloured water tower, a gathering place

for Bedouin with their camels and donkeys. The camp is surrounded by five miles of barbed wire fence illuminated at night by sixteen searchlights mounted in towers and placed intervisably from one another. The perimeter fence is constantly patrolled by armed guards with dogs.

The bulk of Canadian officers and men in UNEF are stationed in Camp Rafah with the servicing and supporting units of the Force. These troops include the UNEF Ordnance Company (RCOC), UNEF Engineer Company (RCE), 56 Canadian Infantry Workshop (RCEME), 56 Canadian Transport Company (RCASC), and 56 Canadian Signal Squadron (RCCS). The housekeeping detachments of Canadian Base Units Middle East form part of Headquarters Company, and consist of Public Relations, Chaplains, Legal, Welfare, Postal, Pay, Medical and Dental Detachments.

DENTAL SERVICES IN UNEF

At the end of January 1962 the total strength of UNEF was approximately 5,150, made of 550 Brazilians, 700 Danes, 600 Norwegians, 400 Swedes, 700 Yugoslavs, 1000 Canadians and 1200 Indians, under command of Lt-Gen PS Gyani of the Indian Army.

Dental care for the Force is provided by 23 officers and men, each national contingent, with the exception of the Indian, having its own dental officer and assistant. Personnel of the Indian contingent receive treatment from the Canadian Dental Detachment. Overall direction and supervision of the six dental detachments has been assigned to the Senior Dental Staff Officer (SDSO), the OIC Cdn Dent Det. He is responsible to the Commander for all matters relating to dental health in UNEF including the planning for dental services and the procurement, issue and control of all dental supplies and equipment.

In addition to military personnel of UNEF, dental officers provide comprehensive treatment for the International Staff (civilians) of UNEF and UNRWA and their dependents, the latter on a re-payment basis. Local employees, Bedouin, Palestinians and Egyptians are treated in an emergency without charge.

With the changing status of the Force from a short-time Emergency Force to one of a semi-permanent nature, more thought was given to the improvement of dental facilities. Field equipment originally brought in with dental officers from various countries has been gradually replaced by UN-purchased supplies and static equipment. These items include regular dental chairs, SSW engines, rubber mats and saliva ejectors and each clinic received an X-ray machine. Improved facilities have contributed greatly to the dental service in UNEF as evidenced by treatment returns during the period Jul 61 to Jan 62 inclusive when dental officers treated an average of 1185.8 patients and performed 1990 operations per month.

There are two laboratory sections in UNEF; a small one for the Yugo Recce Bn, and a larger, more fully equipped laboratory in the Cdn Dent Det to provide prosthetic services for all other contingents. It is interesting to note that initially the Yugo dental officer regularly used more dental gold in one month than the Canadian dental laboratory used in six. However, a new policy was instituted in Jul 61 which authorized both laboratories to be issued gold on a pro rata basis according to the number of personnel served. These laboratories provide all types of laboratory services with the exception of chrome-cobalt castings.

CANADIAN DENTAL DETACHMENT CBUME

The Cdn Dent Det CBUME is unique among the detachments of the RCDC in that it may be called upon to treat soldiers of seven different nations along with civilian personnel from widely separated parts of the world.

There are ten RCDC personnel in the detachment consisting of three dental officers and three assistants, two dental technicians (lab), one dental storeman and one clerk administrative.



Front Row: L to R: Sgt Boulanger, Sgt Storms, Sgt Strub

Back Row: L to R: Sgt Dancer, Capt Arpin, Major Small, Capt Bunt, Ssgt Schell

Not Present: Cpl Moran and Sgt Drawe

Working hours are from 0700 to 1315 hours daily except Sunday, winter and summer. Dental sick parade for Canadian personnel is from 0700 hrs to 0730 hrs, and for Indian personnel from 1030 to 1100 hours. The remainder of the working day is taken up by appointments. Despite the widespread but erroneous opinion that the Cdn Dent Det CBUME has little or nothing to do, it has been determined that during the period from Jul 61 to Jan 62 the detachment averaged 482.5 patients and performed 750.5 operations per month and in many cases, patients were encouraged to defer treatment until they arrived in the Middle East. While it is true that the waiting period for an appointment is rarely more than two weeks, it is definitely incorrect to assume that the dental staff are on a protracted holiday.

For a description of the clinic and its environs, and a general summary of the many opportunities for travel in this area, the reader is referred to the excellent comprehensive and informative article by Cpl CC Eastwood in the Jul 60 issue of the RCDC Quarterly. There have been some notable improvements since then, such as the complete renovation of the stores section and the laboratory including installation of a tile floor and new benches, new tile flooring in the men's quarters and the addition of high-speed units to the clinic. However, Camp Rafah itself hasn't changed. There is still the searing heat of midday and the raw cold of the desert night; still the barbed wire fences and the never-ending sand stretching to the horizon. Postings to faraway places are a normal part of service life, and must be accepted as such. There are few indeed who would regard this as a highly desirable posting, and fewer still who would volunteer for a second tour but actually, except for the separation from home and family, it is not intolerable. Opportunities for travel are good, the weather is generally excellent, and as long as one keeps one's leisure hours occupied, the year passes rather quickly.

CONCLUSION

Generally speaking, Canadians like other troops serving in UNEF are conscious that they are part of a Force specifically designed to prevent war, not to wage it. Irksome as duty in the Middle East may be at times and filled as it is with petty annoyances, the fact remains that without the Force this area would

not long remain quiet and could well become a trouble spot leading to a general conflict. As long as the underlying problems remain unsolved there will be a need for UNEF to reduce border incidents and prevent violations of armistice agreements. Canadian soldiers wearing the blue beret are justifiably proud of the role they are playing in maintaining the peace and helping in some small way to keep order in this troubled world.

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SEVERE HYPOTENSION ASSOCIATED WITH A XYLOCAINE INJECTION

REPORT OF A CASE

Capt FW Lovely, DDS

The patient, a 30-year old petty officer, was referred to Canadian Forces Hospital Halifax because of a hyperactive gag reflex. He had vomited on two previous attempts to position an intra-oral film packet for an X-ray view of the lower left 7-8 area, prior to the extraction of these teeth.

On arrival at CFH Halifax the patient had an extra-oral radiograph taken and an examination was made of the area. A brief history was obtained at this time and the patient stated that he had received a xylocaine injection previously for the removal of a wart on his foot with no untoward effects. He stated that he had developed a rash when being treated with penicillin for a prolonged period a few years previously. The patient was of normal weight and appeared healthy. He gave no further pertinent medical history.

During the systematic questioning of this patient it was noticed that he was extremely apprehensive. He was given an appointment for the next morning for 0900 hrs.

On reporting to the Dental Clinic the following morning the patient was given Meperidine 75 mg. and Promethazine 50 mg., put to bed on the ward and immediately went to sleep. One hour later he was brought to the Dental Clinic.

The patient was placed in the chair in the horizontal position. Approximately 1 cc of xylocaine 2% containing 1/100,000 adrenalin was administered as a mandibular block. The needle was withdrawn and inserted for a long buccal injection and approximately 0.25 cc was injected. Immediately the patient stated that he was fainting.

The dental nurse promptly started administering oxygen at the rate of nine litres per minute. The patient was pale at this time but not cyanosed, his respiration had ceased and his radial pulse was undetectable. Oxygen was continued and closed-chest heart massage sternal pressure was started using the method described in the article on "Cardiac Massage" published in the April 1961 edition of the RCDC Quarterly.

A passing nurse was summoned and instructed to load a dental syringe with a 1 cc carpule of 1/1000 adrenalin, which was in the emergency tray. This was given i.m. in the arm. Heart massage was continued and after approximately one minute the radial pulse became detectable. The pulse was rapid and very thready at this stage and the patient was showing cyanosis around his ears, neck, fingers and toes.

About five minutes later the patient started to breathe on his own but during the next ten minutes his respirations continued to halt whenever artificial respiration by the thoracic pressure method was discontinued. The patient was given 20 mg. Benadryl i.m. at this time.

Once pulse and respiration returned to normal, the chief anesthetist was called from the operating theatre. His appraisal of the immediate situation was as follows: "I saw the patient a few minutes after the episode and at that time he had moderate cyanosis of the fingers and toenail beds although he was breathing well and receiving oxygen by mask. His blood pressure at that time was 110/80, pulse 80/min. He was fully conscious, well orientated, bright and cooperative. In a further few minutes the cyanosis was not as evident. It is impossible to say for certain whether this was an actual case of cardiac arrest or a vaso-vagal syncope." Subsequent to this appraisal the anesthetist called the Chief of Medicine, who examined the patient, advised us to continue ventilating him with oxygen and made arrangements to move him to a private cabin, where an ECG would be taken.

The report of the Chief of Medicine on the ECGs, and his opinion of the situation is quoted hereunder: "When seen by me about 20 minutes after the incident started, the patient was pale but not cyanosed and he was normally orientated and responding appropriately to questions. I gathered that there was no confusion on regaining consciousness. When put to bed, his blood pressure was 110/80 and he felt reasonably well though weak and shaky. An ECG was taken about 40 minutes after the incident and was abnormal showing a general low amplitude T-wave pattern with an inverted T2, T AVF and a biphasic T in V4-V6. The patient was kept in bed and about three hours later a second ECG was recorded. This was entirely normal.

My interpretation of the incident is that the patient became profoundly hypotensive and that the transient ECG changes can be attributed to a period of moderately severe myocardial ischaemia associated with hypotension. I doubt if the heart actually stopped because his recovery of full consciousness was apparently rapid when he responded to treatment. However, with efficient closed-chest heart massage, the circulation including the cerebral circulation can be efficiently maintained and because of the prompt and most efficient treatment he received his circulation was probably never seriously deficient.

It is of interest that I investigated this man four years previously because of a tendency to "faint" on parade and after any mildly traumatic experience. After full investigation including ECG, I decided he was a hypotensive man with lack of good postural vascular tone. No doubt this is relevant to the recent incident."

It was decided two days later that the patient's condition was suitable for a general anesthetic and he was booked for the operating theatre for the following day. The anesthetist's report of this anesthesia stated:

"Pre-induction BP 105/80, pulse 80 and regular. The patient was induced with 300 mg. of sodium pentothal followed by 50 mg. of succinylcholine and 2.0 mg. of sincurine. Intubation was carried out with a number 40 cuffed endotracheal tube and anesthesia was maintained with Nitrous Oxide 5 litres per minute, Oxygen 3 litres per minute and 0.25% Fluothane under controlled respirations.

During the operative procedure the blood pressure gradually rose to 140/85 at the end of the procedure and the patient awakened quickly and was talking intelligently before leaving the theatre. He had an uneventful recovery-room stay. When seen later in the afternoon his condition was satisfactory."

Comments

This is a frightening experience, so frightening in fact that one does not think clearly enough to systematically search for equipment, medications or knowledge. These aids must be readily available at all times. It is also worth noting that a dental officer cannot cope successfully with such a situation single-handed. He and his assistant must be thoroughly familiar with the procedures to be carried out when a cardiac arrest is first detected - Seconds Count.

It has been stated in the literature that time spent in giving adrenalin is valuable time wasted, that one should get busy with closed chest cardiac massage and artificial respiration. The brain, heart and other vital tissues will not suffer damage if perfused with well oxygenated blood and it has been proven that this is possible with an arrested heart, simply by aiding it with closed-chest massage and maintaining respiration with 100% oxygen.

There are several things that could have been done differently. For example, the adrenalin might have been injected in the root of the tongue to permit speedier absorption. In this particular case Benadryl was given perhaps because of repeated discussions of allergic reactions but in any event, the patient is alive, unimpaired and attending lectures today. He could well not have been. These hazards don't always "happen to the other fellow". They can happen in any dental clinic and the patient's life depends upon our knowledge, ability, and equipment.

Conclusion

To cope with such a situation in a dental clinic, the following essentials are mandatory:

1. A thorough knowledge by all the staff of how to deal with the situation viz, the knowledge and ability to administer closed-chest cardiac massage, the ability to maintain respiration by an oxygen bag, mouth to mouth resuscitation or thoracic pressure and the knowledge of how to administer appropriate medications.
2. 100% oxygen, available, operating, and in an accessible position.
3. A tray with emergency drugs and syringes, handy and ready to use within seconds.

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Case Report by Major JVP Chatwin

A 45 year old white male was admitted for dental clearance. He had a history of chronic necrotic gingivitis. Following operation he developed a clinical and laboratory case of acute necrotic gingivitis with widespread osteitis of the exposed alveolar ridges. Bone sequestration occurred. Penicillin was not effective but tetracycline did control the condition. Hospitalization lasted 13 days. This case is interesting for two reasons: (a) It is the first case seen in five years here with N.G. following dental clearance and (b) Penicillin which is specific and dramatic in the control of this infection did not work. It is the first case requiring tetracycline treated at this clinic.

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A PRACTICAL APPROACH TO THE DENTAL EMERGENCY

Major JVP Chatwin, DDS
Surg-Capt MH Little, CD MD

True emergencies are relatively rare across Canada during the course of a year and one tends to depreciate the potential risk. In the hustle of a busy practice the dentist subconsciously depends on outside help from his medical confreres, fire department or the box of "Assorted Emergency Cartridges" supplied by one of the manufacturers. In the heat of an emergency, even in clinics where adequate emergency kits exist, few will be able to recall with certainty, how much of which drug to use where, in any specific case. To clarify this problem for the clinics here, a Card (Fig. 1) has been produced, which lists the procedures. Drugs, dosages and condition are in large type and in contrasting colour. This card is hung in the operating clinics so that the dentist does not have to depend on memory if an emergency should arise. Fig. 2 details the action, use and method of injection of those drugs incorporated in the Royal Canadian Dental Corps Assorted Emergency Cartridges' issue.

The contents of the emergency kit developed here which are all standard medical items are as follows:

Sodium Pentothal, 0.5 gms.	2 vials
Adrenalin Chloride, 30 cc	1 vial
Benadryl Hydrochloride, 10 cc	1 vial
Neo-synephrine, 0.2%	2-2 cc vials
Nitro-glycerin 1/100 gr (0.6 mg)	100 tabs
Amyl Nitrite	12 amps
Aromatic Ammonia	12 amps
Injection water (20 cc)	2 vials
Syringe, 20 cc - 1	No 19 Needles - 2
Syringe, 5 cc - 1	No 23 Needles - 2
Rubber tubing for tourniquet	1 yard
Airway	1
Oxygen apparatus	1
Sphygmomanometer	1

PHARMACOLOGY 1,2

PENTOTHAL

Action - Pentothal is an ultra short acting hypnotic, one of the barbiturate group. It is a respiratory depressant.

PENTOTHAL (cont'd)Preparation

- a. Dissolve powder with 5-10 cc of sterile water.
- b. Transfer back to 20 cc water vial for correct dilution.

Induction - Moderately slow. Give pentothal intermittently in small enough doses to bring the patient to the desired level without appreciable respiratory depression. The absence of reaction to the "pinch test" is a fairly reliable indication that sufficient pentothal has been given. This will minimize the possibility of overdosage. When laryngospasm occurs moderate adduction of the vocal cords may be recognized by a high pitched "crowing" during inspiration. Early recognition and treatment of these causes of stridor or "crowing" will usually prevent the development of severe or true laryngospasm. Careful aspiration to remove any mucous or other substance stimulating the cords is often all that is necessary. Keep the lungs well ventilated with air or oxygen. It is essential that adequate oxygenation is obtained. It is important to maintain airway and have suction machine available.

Signs of Induction

- a. Eyes - will show the pupils dilating at first then contracting.
- b. Pulse - remains normal or soon returns to normal after a slight increase.
- c. BP - a moderate but transient fall is typical.
- d. Muscle Tone - moderate relaxation follows after a lag of about 30 seconds. The tone of the jaw muscles is a fairly reliable index.
- e. Respiration - there is a decrease in the amplitude of respiration.

Deposits of pentothal outside the vein - In a few cases there have been severe reactions to this treatment. Induration soreness, lasting several hours to several weeks. Intra-arterial injections usually cause arterial spasm, manifested by blanching of the skin over the distribution of the vessels and its branches to the site of injection. This may be accompanied by thrombosis of the major vessel. If the patient is conscious he will complain at once of a burning sensation followed by severe pain radiating below the site of injection. Stop the injection. Avoid inadvertent intra-arterial injections by aspirating before injection.

EPINEPHRINE (ADRENALIN CHLORIDE)

Action - It is the active principal of the adrenal medulla. It is prepared synthetically, and is not effective by mouth because it is destroyed by the gastro intestinal juices. It increases the blood pressure through direct myocardial stimulation, increases the heart rate and the peripheral vasoconstriction of the finer arterioles. It has a direct stimulating effect on the cardiac muscle and the conduction tissue. It is used in the treatment of allergic conditions including angioneurotic edema, and acute anaphylactoid reactions. The drug is used by injection for cardiac or circulatory failure and also is the drug of choice in serious immediate allergic reactions. Contra-indications to its use include cerebral arteriosclerosis, hypertension and shock.

Method - Intramuscular injections with brisk massage at the site of injection will hasten the action of the drug. When used by intracardiac injection the dose is 1 cc of the stock solution.

BENADRYL HCl

Action - Benadryl is used successfully as an antihistaminic agent in various allergic entities and has been employed to a lesser extent as an antispasmodic. It is effective parenterally in severe angioneurotic edema and certain drug reactions, eg, penicillin, insulin. Satisfactory results have been obtained in acute asthmatic attacks.

Method - May be administered intravenously or intramuscularly but the intravenous route is preferred in urgent conditions dealt with here. Prompt response is desired in combating the allergic reactions occasionally encountered. Intramuscular injections of benadryl may cause local tenderness, induration and erythema. Parenteral therapy is discontinued as soon as a substantial reduction in the severity has been accomplished. There is no evidence of delayed or cumulative action, side effects or incompatibility to benadryl.

NEO-SYNEPHRINE HCL

Action - Action is similar to that of epinephrine. It is used for its vasopressor effects, to combat states due to peripheral circulatory collapse. More blood is diverted to the central circulation as a result of its peripheral vasoconstrictive action.

Method - It is injected intravenously.

AMYL NITRITE

Action - It is a yellowish volatile flammable liquid with a peculiarly pungent odour. It is supplied in fragile glass ampules covered in a woven fabric. It is used to rapidly dilate the coronary vessels in angina pectoris, also used in bronchospasm. It is effective within 30 seconds but its duration of action is very short. It relaxes the coronary vessels by direct action. Side effects include marked flushing and throbbing of the head. It should be used with caution in patients with glaucoma or cerebral haemorrhage.

Method - Inhaled while in a sitting position.

AROMATIC AMMONIA

Action - Ammonia is an aromatic hydroalcoholic solution containing approximately 4% ammonium carbonate. It is a reflex respiratory stimulant by virtue of peripheral irritation of the sensory receptors in the nasal membranes, esophageal mucosa and the fundus of the stomach. This indirect action by nerve reflex stimulates the circulation.

Method - Inhaled in the sitting position.

SUMMARY:

A practical approach to the potential dental emergency is suggested. A list of common drugs, their doses, method of administration and pharmacology have been discussed.

The brain tissue can survive 3 to 5 minutes total deprivation of oxygen, therefore when breathing stops or is markedly depressed, assistance must be given by some means of artificial ventilation -- a whiff of air now, may do what Penta-costal gales of oxygen cannot do 30 seconds later to save a failing heart.³

REFERENCES

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Fig. 1EMERGENCY PROCEDURESSYNCOPE

1. Patient into lying position.
2. Aromatic Spirit of Ammonia.
3. Get OXYGEN ready.
4. Get Sphygmomanometer ready.

APNEA

1. Give OXYGEN. (Bag 16-20/min) or
2. Use Brooke airway, or
3. Mouth to mouth respiration.

CONVULSIONS

1. 2 cc of 2½% PENTOTHAL stat. I V
30 sec p.r.n.
2. Set up suction machine,
endotracheal tube and vaseline.

VASCULAR COLLAPSE

1. NEO-SYNEPHRINE HCl stat. ½ cc I V
0.2 mg/cc prep. 2-5 min p.r.n.

ALLERGIC EDEMA

1. BENADRYL 25 mg 3 cc stat I V or
2. ADRENALIN 1:1000 ½ cc. sc

BRONCHOSPASM

1. Patient head down and turn to side
(Trendelenburg position)
2. Bag with OXYGEN
3. ADRENALIN 1:1000 ½ cc sc q20 min.

ANGINA PECTORIS

1. AMYL NITRITE or
2. NITROGLYCERIN tablets. 1:100 gr.

Fig. 2ROYAL CANADIAN DENTAL CORPSASSORTED EMERGENCY CARTRIDGESAtropine Sulphate

1/150 gr-1 cc.

Action: Vagal blocking agent-overcomes bradycardia.Use: Circulatory collapse.Method: Inject iv.Caffeine Sodium Benzoate

0.45 gms.-1 cc.

Action: Increased blood flow and may give rise in BP and respiratory stimulation.Use: Collapse.Method: Inject im.Phenylephrine Hydrochloride

1:500 - 1 cc.

Action: Vasopressor.Use: Vascular collapse.Method: Inject iv, and add atropine sulphate.

REBASING COMPLETE DENTURES

Lt Col G MacDougall, CD, DDS, BSc

Rebasing is the process of refitting a denture by replacing the denture base material and maintaining or re-establishing the correct occlusal relationship of the teeth.

The tendency to over-simplify an exacting procedure generally accounts for a large percentage of failures. For example, it is common practice on the first appointment to trim the peripheries, muscle-mold with modelling compound, apply a free-flowing impression material over the tissue surfaces of the dentures and then send them to the laboratory for completion.

The aim of this article is to indicate why such procedures often fail and to emphasize the considerations necessary to achieve a greater degree of success. According to Landa⁽³⁾ "Greater experience and more training are required to accomplish both proper relief of pain from dentures and denture correction than are required for the initial construction". If rebasing procedures are viewed in this light, a greater measure of success will be attained.

Abused Tissue

All abnormalities of the soft tissues beneath dentures should be recognized and treated. They may be caused by systemic disturbances or by mechanical factors associated with ill-fitting dentures. The mechanical factors only will be considered in this article.

The mechanical abuse of soft tissues beneath dentures may be evidenced by slight displacement of tissues in some cases, or trauma, inflammation and gross deformation in others. These conditions are frequently accompanied by loss of retention, lack of stability and changes in the occlusal relationship. When the soft tissues are displaced within normal physiological limits, they tend to return to their rest form, however, if they are subjected to excessive stress, they become deformed, traumatized, less resilient and do not readily return to their normal contour. The mechanical factors which abuse tissue are: incorrect tissue contour or coverage in the denture base, occlusal disharmony, and inadequate free-way space. These factors will be briefly considered in the order given.

The tissue contour of the denture base is probably the most important of these factors. After extractions have been completed, the new bone attempts to build up to the height of the interseptal bone and to the height of contour of the buccal and lingual plates. Therefore, it is important not to have protuberances of base material extending into bony sockets. If they are present on a denture base they should be removed so that the tissue can assume its normal contour.

Over-extension and under-extension of the denture base may cause tissue distortion. Mandibular denture bases should cover the buccal shelf and the retromolar pad. The buccal shelf is one of the most stable bony areas of the mouth and provides an excellent area for stability and support of the lower denture. Maxillary denture bases must cover the tuberosities completely.

Occlusal disharmonies also cause tissue distortion. It has been common practice when new dentures are inserted to dismiss the patient with instructions to return for occlusal corrections after the dentures have "settled in". Gross

occlusal discrepancies in such instances may be concealed because of the ability of tissues to accommodate ill-fitting dentures. Tissue distortion from this cause may be painless and if the tissue is permitted to recover by leaving the dentures out for a period of time, it will become evident that the occlusion is not balanced. It is, therefore, most important to record jaw relations and re-mount the dentures on the articulator to balance the occlusion before the dentures are inserted.

If the vertical dimension of occlusion is too great, (that is, if the free-way space is inadequate) the patient will eventually gain additional free-way space, but this will be at the expense of the underlying tissue.

Treatment Plan for Abused Tissue

In order to permit tissue recovery, a treatment plan must be instituted which may include any or all of the following steps for eliminating or minimizing the mechanical factors causing abuse:

1. Correct the tissue surface of the denture by locating and relieving areas causing excessive pressure and deformation.
2. Correct gross occlusal discrepancies causing instability and trauma.
3. In extreme cases, use a free-flowing, temporary reline material, such as a zinc oxide impression paste, after the dentures have been left out overnight. This improves their stability. It may be necessary to remove the reline material and repeat the procedure every few days.
4. Minimize stresses with a soft diet and removal of the dentures at night.
5. Instruct the patient to stimulate the soft tissues by massage.
6. Leave the dentures out of the mouth forty-eight to seventy-two hours before impression taking.

Success in obtaining tissue recovery depends upon the patient's co-operation which is influenced by the dentist's convictions as to the importance of the procedure.

Feasibility

Rebasing dentures over deformed and traumatized tissue will merely perpetuate both the condition of the tissue and the factors which caused that condition. Only after tissue recovery has been achieved is it possible to determine the feasibility of rebasing dentures. Unless the following requirements can be met, rebasing is impractical and new dentures are indicated:

1. Normal vertical dimension, a balanced occlusion and acceptable esthetics;
2. Correct position of the occlusal plane and acceptable intercuspation of the teeth;
3. No interference with function and phonetics.

The importance of using an exacting rebase technique cannot be ignored when it is realized that in one operation an impression is taken, peripheral borders are developed and the vertical dimension and the occlusal plane established.

Technique for Rebasing the Maxillary Denture

1. All internal tissue surfaces are relieved and undercuts removed.
2. All peripheral areas are reduced at least two millimeters short of the intended peripheral extensions.
3. Hard bony crest areas of the maxillary ridge are located and four modelling compound stops are placed inside the denture base over these areas. By adjusting the stops, the desired occlusal plane is established.
4. Having established a solid seat for the denture with the stops, peripheral trimming is done with modelling compound (as with an impression tray).
5. Using zinc oxide and eugenol impression paste, the impression is completed.
6. At this time, the upper denture is left in position in the mouth.

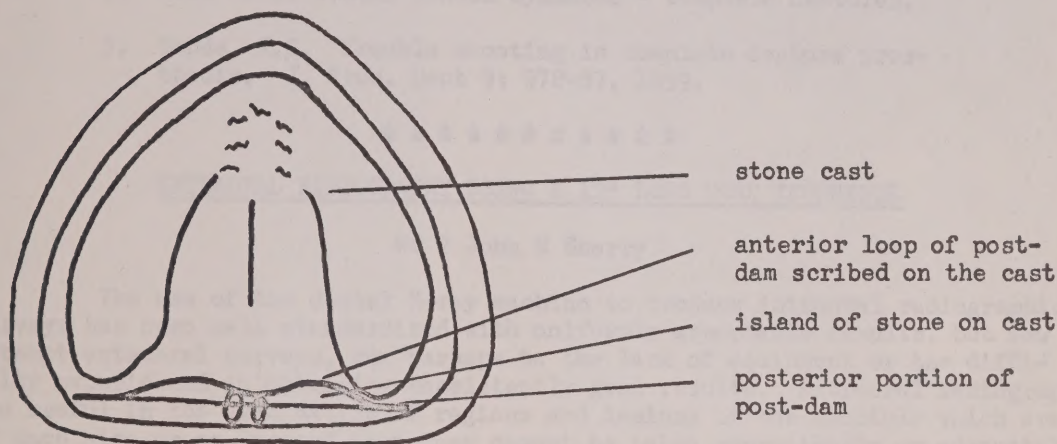
Technique for Rebasing the Mandibular Denture

1. Tissue surfaces and peripheral borders are relieved as described for the maxillary denture.
2. Hard bony crest areas of the mandible are located and four compound stops placed in position.
3. Having softened the compound stops, the patient is directed to close gently until the desired vertical dimension of occlusion is obtained.
4. Using zinc oxide and eugenol paste the mandibular impression is completed, but the patient is not permitted to bring the teeth into occlusion. If an attempt is made to obtain a better occlusal relationship at this time, the underlying tissues will be displaced.

Laboratory Procedures

1. The dentures are boxed and stone casts poured.
2. Care must be taken to preserve the impression paste over the crest of the ridges when separating the dentures from the casts.
3. All compound and impression material except that material over the crests of the ridges is cleaned off the dentures.

4. The dentures are resealed on the casts, peripheries waxed up and laboratory procedures continued in the usual manner. When porcelain teeth are involved, easy separation of the old denture base material from the teeth can be achieved by placing the flasks in a burn-out oven at 350° F for eight minutes.
5. The dentist should determine the position of the post-dam and should scribe it on the cast. Its position is normally from hamular notch to hamular notch and through the fovea palatina. A narrow double post-dam (as shown in the illustration) is recommended and it may be scribed on the cast with a number five round bur.



The posterior border of the denture should extend slightly beyond the post-dam.

The purpose of a post-dam is to displace tissue. Displacement with this type is rapid and minimal and is necessary in the technique for "patient remount" to be described.

Patient Remount

The procedures recommended immediately prior to the insertion of new dentures should also be employed with rebased dentures. Occlusal disharmonies quickly cause tissue distortion beneath denture bases and when this occurs the rebasing operation is doomed to failure. If occlusal balance is to be achieved, a "patient remount" is essential.

When the patient returns for his rebased dentures, a face-bow record is taken and the upper denture mounted on an adjustable articulator. Both dentures are placed in the mouth for the first time but the patient is not permitted to close them. A cotton roll is interposed in the first molar area on each side and the patient is instructed to close tightly on the rolls for 5-10 minutes, thus permitting seating in the post-dam area without the influence of unfavourable inclined planes. This procedure is made possible by employing the narrow double post-dam and permits accurate bite registrations for the "patient remount" at this time.

Centric and protrusive registrations are made by interposing quick-setting plaster or modelling compound between the teeth and not permitting closure quite through the material. This operation should be repeated until the registration can be proved. The centric registration is used for mounting the lower denture on the articulator, and the protrusive registration for adjusting the condylar elements. The dentures can now be "ground in" to achieve occlusal equilibration and when this has been accomplished they are ready for delivery to the patient.

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EXTRAORAL RADIOGRAPHY USING A 12" LONG CONE TECHNIQUE

WO 2 John M Sherry

The use of the dental X-ray machine to produce intraoral radiographic surveys has been well standardized with uniformly acceptable results, but few attempt extraoral surveys, due perhaps to the lack of equipment or the difficulty experienced in obtaining consistently good results. Extraoral radiographs are useful in the examination of regions and lesions of the mandible which are of such size or so located that they cannot be taken conveniently or adequately by the intraoral technique. A complete radiographic service warrants wider use of the "long cone" in dental practice.

A technique is described for two basic projections using a long cone to show:

- a. The posterior body and ascending ramus of the mandible, and
- b. The anterior portion of the body of the mandible.

This technique does not vary greatly from standardized procedures reported in the literature but it has been found that working from a basic position, using the 3" x 12" cone, results are acceptable, uniform and easily obtained.

This procedure in the dental office involves:

1. No additional equipment, special headrests or movement of the patient to another area.
2. A basic alignment of the patient, machine and film from which specific modifications of the patient's head position are made to routinely produce the two required views.

TECHNIQUE

a. Posterior Body and Ascending Ramus of the Mandible

This radiographic view favours, without significant distortion, the third molar area, the inferior and superior borders of the mandible and a portion of the ascending ramus and usually shows the shadow of the mandibular canal.

In the basic position, the subject is seated upright in the dental chair with the sagittal plane of the head vertical and ala/tragus line horizontal (Fig. 1). Final orientation of the patient's head is achieved by movements from this basic position.



(Fig. 1)



(Fig. 2)

The 5" x 7" cassette is positioned against the patient's head and rested on the shoulder with its lower edge supported by the hand, fingers spread on the back of the cassette (Fig. 1). The elbow is kept close to the body to attain stability. With the teeth in occlusion the chin is tilted upwards and forward approximately 1" to 1½". The head is rotated until the ramus to be examined is pressed against the cassette and the nose almost touching (Fig. 2). This is important since it eliminates superimposition of the opposite body of the mandible or the hyoid bone. The vertical centre line of the 5" x 7" cassette is positioned two inches posterior to the outer canthus of the eye.

The average vertico-horizontal angulation is - 17° with the central ray directed ½ inch posterior and inferior to the angle of the mandible on the side not under examination. The usual exposure is 3/8 seconds at 65 KVP and 10 MA for Kodak Blue Brand Medical X-ray film in a cassette with intensifying screen.

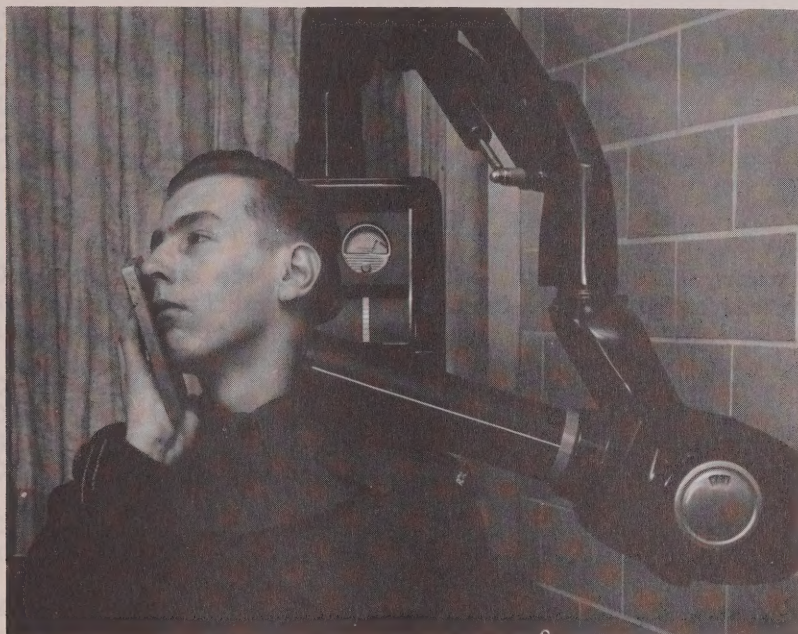
Common Errors

1. The cassette is held against the malar bone rather than against the mandible. This changes the vertico-horizontal angle, and produces elongation or foreshortening.
2. The central ray is directed too far anteriorly, resulting in insufficient definition in the desired area. In addition, the shadow of the hyoid bone is cast across the third molar area.

b. Anterior Body of the Mandible

This projection provides a clear view of the anterior portion and the main body of the mandible, commonly described as a lateral jaw examination. The area of the mandible included in this examination extends from the cuspid to the third molar. The maxillary molar region also appears in this view.

The basic position is the same as before and the final orientation is again achieved by deviation from this basic position. The elbow is kept close to the body to attain stability. The head is rotated until the anterior portion



(Fig. 3)

of the body of the mandible to be examined is pressed against the cassette. With the teeth in occlusion, the chin is thrust upwards and forward approximately 1" - 1½", and the head rotated until the nose is pressed against the cassette (Fig. 3). The average vertico-horizontal angulation is - 10° to - 15°. The central ray is directed anteriorly to pass below the third molar on the side not under examination.

Common Errors

1. The cassette is against the malar bone rather than against the anterior portion of the body of the mandible, resulting in superimposition of the opposite side of the mandible and/or foreshortening.
2. The central ray is directed too far anteriorly resulting in insufficient definition in the area of the second and third molars.

Summary

A technique for the extraoral examination of two portions of the mandible with the use of the 12" long cone has been presented. It provides standardized procedures for radiographing two areas of great importance to the referring dentist, requires a minimum of accessory equipment and no alteration to the dental chair. Working from the basic position, the technique described is easy to master and produces radiographs of good diagnostic value.

PROMOTIONS

Congratulations to the following Corps personnel and airwomen on their recent promotions:

Sgt	EL	Schell	-	to A/Ssgt) whilst so
Cpl	G	Dancer	-	to A/Sgt) employed
Pte	JARG	Rochon	-	to Cpl
Pte	CStC	Sabine-Paisley	-	to Cpl
Pte	RH	Stenabaugh	-	to Cpl
Pte	WW	Webster	-	to Cpl
Cpl	JA	Brennan	-	to Sgt
LAW	D	Ellis	-	to Cpl
LAW	DAM	Fisher	-	to Cpl
LAW	MLG	Larue	-	to Cpl
LAW	JA	Rathe	-	to Cpl
LAW	GAM	Ridley	-	to Cpl

RELEASES AND RETIREMENTS

Our good wishes are extended to the following RCDC personnel, RCAF airwomen and Part V civilians who have retired or have taken their releases during this Quarterly period:

Capt	EG	Baird	-	Picton
Capt	AP	Menzies	-	RCAF Stn Chatham
Sgt	V	Krymlak	-	DT Lab, RCAF Stn Namao
Cpl	J	Wareing	-	DT Lab, Shearwater
Cpl	MM	Potolicki	-	DA, 35 Fd Dent Unit
AW2	JM	Chekaluk	-	DA, RCAF Stn St Jean
Mrs.	MMB	Van Scherremburg	-	Pt V DA, Petawawa
Mrs.	SD	Parks	-	Pt V DA, Griesbach

WELCOME

A warm welcome is extended to the following new members of the RCDC and RCAF airwomen:

Pte	JB	Arsenault	-	12 Dent Coy
Pte	RS	Black	-	12 Dent Coy
Pte	HL	Boring	-	11 Dent Coy
Pte	AH	Hannay	-	11 Dent Coy
Pte	DH	Hardy	-	12 Dent Coy
Pte	GED	Hays	-	No 1 Dent Eqpt Dep
Pte	WD	Horne	-	12 Dent Coy
Pte	DF	Ife	-	13 Dent Coy
Pte	LJJ	Nadeau	-	1 Dent Eqpt Dep
Pte	R	Taillon	-	13 Dent Coy
AW2	DJ	Kokoski	-	RCAF Stn Downsview
AW2	JM	Roberts	-	RCAF Stn St Jean

POSTINGS

Capt	DS	Campbell	-	to CFH Halifax from HMCS Cape Scott
Sgt	EV	Tanner	-	to HMC Dockyard Halifax from HMCS Cape Scott
Sgt	MG	Dean	-	to HMCS Naden from HMCS Cape Breton
Sgt	JA	Christiansen	-	to 11 Dent Coy from CBUME
A/Sgt	GD	Dancer	-	to CBUME from 25 COD Longue Pointe
Cpl	CM	Martell	-	to 12 Dent Coy from CBUME
Sgt	VH	Shaw	-	to 8th Cdn Hussars Fort Beausejour from HQ 4 CIBG
Sgt	GH	Storms	-	to CBUME from RCSME Vedder Crossing
Sgt	JR	Yeates	-	to QM Stores Winnipeg from No 1 Dent Eqpt Dep
Sgt	WH	Fougere	-	to HMCS Stadacona from HMCS Cape Scott
Sgt	JAR	Shields	-	to HMCS Cape Breton from HMCS Naden
Cpl	WE	Bussell	-	to Fort Osborne Bks Winnipeg from 7 PD London
Cpl	EJ	Lansey	-	to 3 RCHA Fort Prince of Wales from 8th Cdn Hussars
Cpl	CC	Millard	-	to HQ 4 CIBG from 3 RCHA
Cpl	D	Ellis (RCAF)	-	to RCAF Stn Gimli from 2 (F) Wing
Cpl	KP	Palmer (RCAF)	-	to 35 FDU from RCAF Stn Downsview
LAW	SAM	Biglow (RCAF)	-	to 35 FDU from RCAF Stn Trenton
Miss	ME	Ward	-	to 11 Dent Coy from 1107 Avenue Rd Toronto

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TRAINING

During the period since 31 Jan 62, Corps personnel have attended the following courses:

TRAININGDoctors' Hospital - Toronto

Maj	WR	Thompson	-	16 Apr - (8 wks)
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Ent Air Force Base - Colorado Springs

Maj	JW	Jolly	-	Oral Surgery 5 Feb - 16 Feb
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Fort Churchill Arctic Indoctrination Course (Staff)

Capt	HW	Brogan	-	22 Dec 61
Capt	RJ	Paturel	-	26 Jan 62

Office Management - RCASC School - 5 Mar - 30 Mar 62

WO2	ESW	Moore
Sgt	GR	Jennings

F/Sgt Course - RCAF Stn Camp Borden - 12 Feb - 23 Mar

Sgt	CMB	Torrens
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TRAINING (cont'd)RCDC SCHOOL COURSESOfficers' Casualty Care and Officers' Clinical - 5 Mar - 6 Apr

Maj	JA	Lauziere
Maj	HR	Kettyls
Maj	PH	Guevremont
Maj	DJ	Carmichael
Maj	J	McGaughey
LCdr	H	Muller III DC USN
Maj	WR	Baze DC US Army

DT Lab Gp 3 - 5 Feb - 16 Mar 62

Sgt	A	Bramble
Sgt	HW	Roberts
Cpl	EPH	Sprathoff
Cpl	TW	Thrasher
Mr	R	McNabney - DVA Civilian

Dent Asst Gp 1 - 19 Mar - 20 Apr 62

Pte	TJ	Deloughery
Pte	JAY	Ferland
Pte	BA	Green
Pte	RB	Johnson
Pte	DL	Kerr
Pte	JM	MacLean
Pte	JA	Mason
Pte	PA	McCoy
AW1	HL	Brooker
AW2	FW	English
AW2	CM	Fraser
AW2	E	Graham
LAW	PLM	Kennedy
AW1	DJ	Kokoski
AW1	DJ	Lawrence
AW2	SJ	McMillan
AW1	DJM	McNichol
LAW	MBA	Perusse
AW1	GW	Poulson
AW1	A	Skubiak
AW2	MY	Smith
AW1	JM	Stangowitz
LAW	DA	Turner

Preventive Dentistry

Even prosthodontics which is considered an end of the line treatment has its preventive aspects. In this regard Dr. M.M. DeVan writing in the March, 1952 Journal of Prosthetic states of prosthodontics, "Our objective should be the perpetual preservation of what remains, rather than the meticulous restoration of what is missing."

VITAL STATISTICSDIRECTORATEBirths

Cpl and Mrs ADT Gardner, a daughter Sharon Tracy, born 23 Mar 62 in Ottawa.

RCDC SCHOOLHospital

Capt A Van Ryssel was a patient in Camp Borden Station Hospital from 3 - 26 Jan 62.

NO 1 DENT EQPT DEPBirths

A son was born to Sgt and Mrs AJ Tait on 5 Apr 62.

Hospital

Sgt JR Yeates spent from 28 Feb to 13 Mar 62 in NDMC Ottawa.

Mr. R Mills, our towmotor operator, suffered a heart attack 12 Feb 62.

Mr. L Faught, carpenter of this unit underwent major surgery on 19 Mar 62.

11 DENT COYMarriages

Miss Shirley Fogg (25 Clinic Griesbach Barracks) was married to Mr George Park in Edmonton on March 10th. The happy couple will reside at Kerrobert, Saskatchewan and leave Edmonton with our best wishes.

Hospital

Most members of No 5 Clinic RCAF Station Namao have been periodically hospitalized or sick in quarters since the first of the year following an outbreak of infectious mononucleosis. Sick are Major JCE McDonald, Capt JB Wilcock, Sgt V Krymlak, Sgt GF Keogh and Cpl Y Dundas. The clinic will remain closed until the staff return to duty and meanwhile treatment for the station is being provided by No 25 Clinic Griesbach Barracks. We hope to hear of a complete recovery of all in the very near future - after all fellows, the golf season is fast approaching.

13 DENT COYBirths

Capt and Mrs KSM Mathers, a son, Shawn Eric McLean, on 12 Feb 62

Ssgt and Mrs JA Fraser, a son, Cameron John, on 5 Mar 62

Cpl and Mrs JF Kennedy, a daughter, Patricia Ann, on 30 Mar 62

Hospital

Major AG Andrews - 22-27 Mar

Capt JW Lincoln - 29 Jan - 9 Feb

Cpl JF Kennedy - 15-18 Jan

Cpl JRE Lalonde - 14 Nov 61 -

14 DENT COYBirths

A son, William Retson, was born to Capt and Mrs HW Brogan of Fort Churchill on 4 Nov 61.

On 11 Dec 61 a daughter, Sandra Jeanne, was born to Ssgt and Mrs FR Taylor at Winnipeg.

To Sgt and Mrs DM Hamilton, a son, John Edward, on 28 Feb 62 at Winnipeg.

Hospital

Cpl DL Fenton was in DVA University Hospital, Saskatoon from 22 - 29 Dec 61.

Pte DL Kerr was admitted to Shilo Military Hospital on 6 Mar and discharged the following day.

15 DENT COYBirths

To Sgt and Mrs SE Robertson, a son on 9 Apr 62.

Marriages

AWL Peck to LAC R Hawryluk at St Jean on 3 Mar 62.

DIRECTORATE OF DENTAL SERVICES NEWSOffice Location Changed

The oft-rumoured and oft-delayed move of this Directorate to No 8 Temporary Bldg took place on 19 Apr 62. All departments are now operating in the rarefied atmosphere of the fourth floor.

Duty Trips and Visits

Brig Baird flew to the Middle East on 26 Feb 62 to inspect the Dental Detachment at CBUME. Details of this visit will be found in Dent Det CBUME News.

Col Shillington visited The RCDC School 13 Mar 62 to inspect the facilities and staff and to talk with candidates attending the various courses in progress at that time. On his return trip he attended a meeting of the Council on Education of the CDA at Toronto.

Maj Brusso recently completed a coast to coast trip during which he inspected the QM Stores and consulted with the Quartermasters of each unit on matters of mutual interest.

Guest Lecturers

Maj Protheroe presented a series of lectures on Clinic Management to the candidates attending the Officers' Clinical Course at The RCDC School in Jan. Lt Col Hillier conducted a similar programme during the second course in Mar.

Maj Brick DCRA Rep

While on leave, Maj Brick represented the Dominion of Canada Rifle Association at the annual convention of the National Rifle Association held in Washington DC from 31 Mar to 5 Apr 62.

Directorate Team in Interservice Bonspiel

Although they finished off the prize list, this Directorate was ably represented in this important event by the following rink:

Maj Brusso	- Skip
WO2 Fisk	- Vice
Brig Baird	- 2nd
Col Millar	- Lead

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RCDC SCHOOL NEWS

Establishment Increased

No 23 Clinic RCAF Stn Camp Borden is now officially part of the School establishment. The School's gain is 13 Dent Coy's loss.

Curling

Capt Chas Casterton was a member of the Camp Borden championship rink that journeyed to Kingston and walked off with the Central Command trophy.

The Garth C Evans trophy for curling supremacy between Medical and Dental Officers of Camp Borden was successfully defended by two School rinks skipped by our genial CI, Lt Col Geoff Bagnall, and Capt Van Ryssel.

The senior NCOs are still battling their medical confreres for the Viau trophy and have a good chance of finishing on top.

Dick and Jan Troxell, late of the USA, have taken to curling like a duck to water. There'll be an extra carton on that moving van for the return trip "down under" clearly marked "Handle with Care, Curling Trophies".

Skiing

Lt Col George MacDougall was able to enjoy a few weekends of skiing between curling bonspiels and claims the Georgian Bay-Muskoka area is a skier's paradise.

Rod and Gun

Thanks to our rod and gun enthusiasts at the RCAF Station Borden clinic, some of us enjoyed a succulent meal or two of venison this year. Capt Bruce Hudgins and Sgt Don Playford bagged their limit on an "expedition" to Manitoulin Island.

Hockey

WO2 Reece Jackson certainly must welcome the signs of spring. Reece has generously given almost all of his free time this winter sponsoring little league

hockey. A natural athlete, Reece excelled at hockey and softball during his playing days and has done a tremendous job with the Camp Borden children. The RCDC School has donated a Trophy for the Best Goalie of the Bantam Division.

Honours and Awards

The following personnel were awarded 1st Clasp to CD:

Capt CA Casterton	-	5 Nov 61
Capt DG Cartwright	-	19 Nov 61
WO2 RWM Hall	-	27 Nov 61
WO2 Jones JM	-	2 Jan 62

NO 1 DENT EQPT DEP NEWS

Curling

This unit and No 3 Dental Clinic personnel now feel they have curlers of sufficient calibre to challenge any other dental unit HQ etc, to a curling match, at a place and time agreeable to all concerned.

WO1 Bergland, Sgt Sullivan and their wives won prizes in a mixed open bonspiel held at Camp Petawawa Curling Club.

A curling rink from this unit proceeded to Kingston to participate in the Command Olympic Curling Bonspiel and reached the quarter finals in the "B" event.

Bowling

Major Fletcher took part in the Olympic Bowling playdowns at London Ont 10-12 Apr 62 as a member of the Camp Petawawa bowling team.

Judo

Ssgt Davison competed in a Judo tournament and grading 24 Mar and received his Blue Belt.

Farewell Party

Officers, NCOs and their wives attended farewell parties held in honour of Col and Mrs Cathcart who will be leaving Camp Petawawa on retirement.

Miss Sharon Lee Davison

Our sympathies are extended to Ssgt and Mrs AF Davison on the death of their daughter Sharon Lee on 10 Apr 62.

11 DENT COY NEWS

Duty Trips and Visits

Colonel BP Kearney visited stations and inspected dental clinics in Vancouver, Chilliwack, Victoria, Comox and Kamloops areas during the period

15 - 24 January. From 1 to 3 February he combined business with pleasure and competed in RCAF Stn Cold Lake's annual "Palmspiel", utilizing the "between games" time to discuss dental problems at that station. Coy QM Stores, 59 Dental Unit (M) and the Currie Barracks clinic were visited 27-28 March.

Capt AG Garden was temporarily employed in 13 Clinic RCAF Stn Cold Lake for a four-week period during Major WH Carter's absence on course.

Captain LK Wansbrough and Sgt JM Moore spent from 3 to 5 April at RCAF Stn Kamloops, ensuring that all is in order for the RCDC to take over the clinic there.

Sgt MF Conkey has made an installation and maintenance tour of clinics at Chilliwack, Vancouver, Comox and Holberg.

Lt Col OW Crummey, QMS EK Abernethy, Sgt RL Thornton and Cpl J Dion provided treatment for personnel at Camp Wainwright 12-23 March.

Sgt GH Taylor was on TD to 13 Clinic RCAF Stn Cold Lake 7-23 February and again 20 March to 18 April to alleviate the rather acute DA shortage caused by sickness and courses.

Major MP Quinn, Sgt GW Wilkinson and Cpl WG Harmer visited RCN Station Masset from 22 January to 6 February.

Major RJK Pyne and Cpl J Dion were on TD to RCAF Stn Holberg 28 January to 18 February.

Major TD Cobb, Ssgt H Hodkinson and Sgt WJ Arnsby proceeded to Dawson Creek 12 February and on to Fort Nelson 18 February where they were joined by QMS Abernethy. The entire team returned to Edmonton 24 February.

Sgt GF McKay was temporarily employed at RCSME Vedder Crossing from 15 January to 16 February.

Annual Dental Meeting

Colonel BP Kearney and Major TD Cobb attended the first annual meeting of the Alberta Dental Association which was held in Edmonton 29-30 March.

Curling

Colonel BP Kearney served as Chairman of the Western Command Invitational Bonspiel held from 12 to 15 April.

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12 DENT COY NEWS

Sports

Capt Hal Bunston led the Shearwater Volleyball team to the Maritime Tri-Service and Maritime open titles. Good luck in the Dominion Finals - Hal.

Capt Jack Quackenbush and his rink won the Stadacona closing Bonspiel and the Second Consolation in the Atlantic Command Bonspiel. He also represented Stadacona in the Provincial Briar playdowns.

Capt Bill Shaw was our able representative at the Eastern Command Basketball championships and the Canadian Army Ski Championships.

WO2 Stan MacLean and Capt Arn Abramson are fast becoming experts in the Judo field. Stan entered the Brown Belt Judo matches at Stadacona recently but "got the chop".

Jack Quackenbush and his rink pulled a rarity on 8 Mar when they built themselves an eight-ender. It was the first perfect-end in local curling circles this season. The curler's dream came on the second end during afternoon play when Quackenbush was tossing them up in RCN Curling Club play. He drew to the house with final rock to give his team the eighth counter. Final tally in the game was 17-7 and the rink accomplished the rarity with only three men.

★ ★ ★ ★ ★ ★ ★ ★ ★ ★

13 DENT COY NEWS

Duty Trips and Visits

Capt Hunter visited the newly-acquired clinics at RCAF Stations Moosonee and Ramore from 11-16 Feb and then proceeded on leave to Kingston, Jamaica to thaw out. Later, Ssgt Everett, accompanied by almost a ton of equipment and supplies fitted out the Moosonee clinic in preparation for the arrival of Capt Reynolds and Cpl Sapergia who will be providing dental treatment from 27 Apr to 25 May. Capt Girard and Sgt Holtham returned recently from RCAF Station Ramore where they spent three weeks on temporary duty.

Ssgt Bill Weir Honoured

The Annual Army Mess Dinner at RCAF Station Trenton Sgts' Mess was made the occasion to honour Ssgt Bill Weir on his imminent retirement. A suitably engraved silver tray was presented to him by the PMC. Col Leman, Lt Col RHG Cunningham, Capt Hunter and WO2 John Sherry were among the many guests.

Cpl JA Brennan Wins Prize in Photo Contest

Congratulations to Cpl JA Brennan who was awarded 3rd prize in the recent "Airwomen's Special Twentieth Anniversary Photographic Contest". She was presented with a cheque by Capt EW Gazo on behalf of the Commanding Officer RCAF Station Trenton.

Dr WO Gardner "Squares-off" in Washington

In early March, Dr and Mrs WO Gardner attended a square dance festival in Washington DC. He reports a wonderful trip and found time between dances to visit Congress and the Smithsonian Institute.

Col Climo Bereaved

Sympathy is extended to Col CBH Climo on the death of his father in late March.

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Capt Bill Shaw was our able representative at the Western Command Staff-
ball championships and the Canadian Army 3rd Championships.

WOL Sean Maclean and Capt Air Anderson are fast becoming experts in the
Judo field. Sean entered the Howe Hall photo contest at Hamilton recently and
"got the chop".

Jack Guckenschuh and his wife called a party on 8 Nov when they had
themselves an eighth-birthday. It was the first party--and in fact a very nice
this season. The couple's third son on the second and during afternoon play
when Guckenschuh was coaching them up in WOL Outing Club play. He then in the
house with final look to give the eighth birthday. Final party in the
gave was 12-7 and the club accompanied the party with only three men.

12 NOV. OUT NEWS

Duty Times and Visits

Capt Hunter visited the newly-acquired minor at RCAF Station Trenton
and returned from 11-12 Feb and then proceeded on leave to Kingston, Ontario to
out. Later, Capt Hunter, accompanied by almost a ton of equipment and supplies
littered and the necessary outfit in preparation for the arrival of Capt Hunter and
Col Sawyer who will be providing tactical instruction from 17 Apr to 22 May. Capt
Givard and Sgt Holmes returned recently from RCAF Station Trenton where they spent
three weeks on temporary duty.

Sgt Bill Weir Hatched

The Annual Army Women at RCAF Station Trenton Sgt Weir was made
the occasion to honor Sgt Bill Weir on his husband's retirement. A military
engraved silver tray was presented to him by the PWG, Col Lewis, Lt Col HNS
Cannaghon, Capt Hunter and WOL Young Sherry were among the many guests.

Col JA Brannon Wins Prize in Photo Contest

Congratulations to Col JA Brannon who was awarded 3rd prize in the recent
"Airwoman's Special Technical Anniversary Photographic Contest". She was presented
with a cheque by Capt Ed Goss on behalf of the Commanding Officer RCAF Station
Trenton.

Dr WO Gardner "Spencer-ET" in Washington

In early March, Dr and Mrs WO Gardner attended a course in the history
in Washington DC. He reports a wonderful trip and found time between classes to
visit Congress and the Smithsonian Institute.

Col Citrus Betrayed

Sparsity is extended to Col Ed Citrus on the death of his father in
late March.

14 DENT COY NEWSNo 1 Clinic Renovated

Extensive changes recently completed in the clinic at Fort Osborne Barracks provide a new operating bay, waiting room, offices and laboratory space.

Curling

The Annual 14 Dent Coy Bonspiel saw eight teams competing for the fine trophy presented by the Commanding Officer. Members of the winning rink were Ssgt Taylor (Skip), Mrs CA Young, Capt Moore and Sgt Young. A most enjoyable dinner and dance followed. Lt Doyle extended a vote of thanks to Sgt Keith Laurence who arranged for both the ice at RCAF Station Winnipeg and for the wind-up party.

A 14 Dent Coy rink has won the Grand Aggregate Trophy of the Fort Osborne Curling Club for this season. Our congratulations to Ssgt Taylor (Skip), Major Lauziere, Lieut Doyle and Capt Moore.

Bowling

The unit Bowling League ended the season's activities with a most enjoyable banquet at the Viscount Gort Hotel on Sat 28 Apr. Our congratulations to all the trophy and prize winners.

Bereavement

Our sympathies are extended to the family of L/Sgt GA Fogg who died on 6 Apr 62.

15 DENT COY NEWSEngagements

AW1 FW English, Dent Asst at RCAF Stn St Jean expects to be married in September to a Pinkerton man (that's his name) from Toronto.

Our "grapevine" tells us that LAW EE Dennis plans to be married in August to an airman from Goose Bay.

Bereavements

Our sympathies are extended to the family of Lt Col PR LaSalle who died suddenly at Montreal on 24 April.

WO2 Moore was recently bereaved when his father died at Springfield, Ont.

Where Are They Now?

AW2 JM Chekaluk recently of RCAF Stn St Jean, gave up service life for the glitter of a cash register in her brother's night club in Edmonton.

Goose Bay

The staff of the clinic are looking after Mrs Robertson and the new baby while "Robby" is at The RCDC School attending the DT Cl Gp 3 course.

Sgt Dorothy Pierce is anticipating her new assignment at RCAF Stn Greenwood with great interest. She has become so acclimatized to the fine winters and beautiful summers of the Labrador area that she expects difficulty in adjusting to the tremendous winter snowfalls and heavy summer rainfalls of lower Nova Scotia.

LAWs Wiens and Dennis have become so fond of serving with the RCDC at Goose Bay that they have both applied for tour extensions.

Sports

Capt "Benny" Parent took a bit of spring leave to try out the golf course. The Russian fallout didn't melt all the snow, however, and he hit more snow banks than sand traps and green combined.

Capt Marcil enjoyed some ice fishing and returned quite red-faced. He called it sunburn (?).

Capt Jack Harrison returned from leave in the Southern States where he and two partners spent a golfing holiday. This included hob-nobbing with the pros at the Azalea Open.

Lt Col JG Butler made the prize lists at the Lakeshore Bonspiel and the Cornwall Men's Bonspiel.

A Pat on the Back to:

WO2 Ed Moore for taking top honours in his class on the recent Office Management course.

Cpl Pete Sprathoff for being tops in his class on the recent Gp 3 DT Lab course.

L/Sgt Erny Jermain for passing a tough Sr NCO Course.

35 FD DENT UNIT NEWS

Duty Trips and Visits

Brig KM Baird was met at 4 (F) Wing Baden-Soellingen by Lt Col LG Craigie on 1 Mar 62, enroute to CBUME.

Lt Col LG Craigie and Capt DH Evans visited all Wings during the preceding quarter.

Maj CJ Sivell, WO2 AG Cross and Sgt JF Marchand proceeded to England 5 Jan to 9 Feb to provide dental services at 30 AMB Langer and CJS London. On 27 Mar Maj FD Charman, Sgt KS Rothwell and LAW JA Bowes made the tour. The newly acquired facilities at the London clinic are pictured on the following page. No wonder this TD to the London clinic is considered the "plum" of the Air Division duty trips!

Maj WH Harrington and WO2 AG Cross went on TD to Decimomannu, Sardinia from 21 Feb to 7 Mar 62. Cheer up men, at least the leather goods are cheap in Cagliari.



CJS Clinic, London, England

L/Sgt SD Posyluzny, DER 4 Fd Dent Coy, visited all Wing Clinics and HQ from 6 Feb to 1 Mar 62.

Lt Col LG Craigie went to Decimomannu 23 Jan to 30 Jan 62 and to 4 Fd Dent Coy and 4 CIBG on 15-20 Feb 62.

CGS Makes Presentation

Lt-Gen G Walsh, CBE, DSO, CD, Chief of the General Staff visited HQ 1 Air Div on 11-12 Feb 62. Following his inspection of the Guard of Honour on 12 Feb 62, Lt-Gen Walsh presented the first clasp to the Canadian Forces Decoration to WO2 AG Cross.



Curling

Maj Hinch, WO1 Loken and Sgt Roberts formed 3/4 of the winning rink in the HQ 1 Air Div Annual Bonspiel held at 3 (F) Wing Zweibrücken on 21-22 Jan 62. The rink won five games and lost none. Shown here is Skip, Sgt Roberts receiving the 1 Air Div Curling Trophy from W/C CS Yarnell, CO Support Unit at Metz.

On 10-11 Feb the same rink placed second in the 1 Air Div Bonspiel at 3 (F) Wing.



Hockey

Cpl WJ Parker was named to the HQ 1 Air Division All-Star Hockey Team on 30 Jan 62. His team subsequently won the 1 Air Division Hockey Championship, defeating 3 (F) Wing 2 out of 3.

Visit to Orphanage

Over the last Christmas period, WO1 CH Loken, visited the Sisters of Sacre' Coeur Orphanage, in his capacity as PMC Sgts' Mess, bringing a little cheer to the Sisters and their charges.

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4 FD DENT COY NEWS

Duty Trips and Visits

A mobile dental sub-section, composed of Maj DH Skinner, WO2 PL Gourlay and L/Cpl W Fiddler Dvr, travelled to Antwerp 4-18 Feb to render comprehensive treatment to the personnel of 1 CBOU and to examine the children of the DND School.

L/Sgt Posyluzny SD visited 35 Fd Dent Unit from 6 Feb to 2 Mar 62 repairing and rehabilitating unserviceable dental equipment.

Curling

A rink composed of Lt Col Evans, Capt Kelly, Sgts Cahill and Hill took part in a curling bonspiel 4-6 Jan 62 sponsored by 1 CDN Gds at Fort York. The RCDC rink finished as runner-up in the main event.

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CBUME NEWS

Leave

Since the last issue of the Quarterly, the following personnel have been to the UNEF Leave Centre, Cairo: Major Small, Capt Arpin, Ssgt Schell; in addition, Major Small and Capt Arpin went on weekend leaves to Beirut.

Sgt Drawe had a three-week tour of Europe visiting relatives in Germany.

Crown and Bridge Clinic

On 24 January, personnel of the Cdn Dent Det held a Crown and Bridge Clinic for all contingent UNEF dental officers. Present at the meeting were Capt 1st Class V Stankovitch and Lieut G Djeordive (Yugoslavia), Lieut R de Deus, (Brazil), Capt O Gronquist (Sweden), and Lieut R Schmidt-Hansen (Denmark), as well as the Brazilian and Yugoslav interpreters. Major Small welcomed the officers and introduced the programme which consisted of two films from Canada on the construction and insertion of immediate temporary bridges. A table clinic was presented by Capt Bunt on the preparation and insertion of a typical immediate bridge and Capt Arpin and Sgt Martell showed a direct impression and casting technique for a permanent bridge to replace the temporary bridge demonstrated by Capt Bunt.

After the table clinics there was a discussion period on the material presented.

The whole clinic, including the laboratory section, was "open house" to the visitors, and all members of the Detachment took part in preparing for the event and answering questions.

As spokesman for the contingent dental officers, Lieut Schmidt-Hansen thanked the personnel of the Detachment for their hospitality and expressed the hope that such clinics could become a regular feature, enabling dentists from various countries to pool their knowledge and experience.

After the meeting the visitors were guests of the Canadian Dental Officers for dinner at the Officers' Mess, Camp Rafah.

Visit of Brigadier Baird

On the last day of February, Brig KM Baird landed at El Arish airfield and was met by Col GF Stevenson, Chief of Staff, and Major Small. Brig Baird's main purpose in coming to the Middle East was to interview personnel of the Canadian Dental Detachment and to inspect dental facilities for Canadian and other United Nations Forces in the Gaza Strip. Due to unavoidable circumstances a re-arrangement of flight plans by the RCAF had to be made and his tour, originally scheduled for one week, was extended to two. This change of plans gave Brig Baird a chance to visit Cairo and Beirut with Major Small.



Front Row - L to R: A/Sgt Strub,
A/Sgt Martell

Second Row - A/Sgt Belanger, Capt
Arpin, Brig Baird,
Major Small, Capt Bunt,
A/Ssgt Schell

Back Row - Cpl Giles, Sgt Storms,
A/Sgt Drawe

Rotation Parties

Since the last issue of the Quarterly, rotation parties were held for Capt Bunt, Sgts Christiansen and Martell, and Cpl Giles, who left for various clinics in Canada on the completion of their tour with CBUME.

New Arrivals

We extend a warm welcome to Sgts Glen Storms, Geoff Dancer, and Tony Strub who have recently arrived from Canada. Our wish is that their tour with CBUME will be a happy one, and that they will avail themselves of the many opportunities to travel throughout the Middle East.

Duty Trips

Capt Arpin and Sgt Boulanger paid a visit to the Recce outposts to see for themselves what life was like in the Squadron. Not to be outdone, Staff Schell went on a tour of the ADL. All three reported that the trips were well worthwhile.

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MILITIA IN THE NEWS

Col. JP Whyte Inspects Special Militia

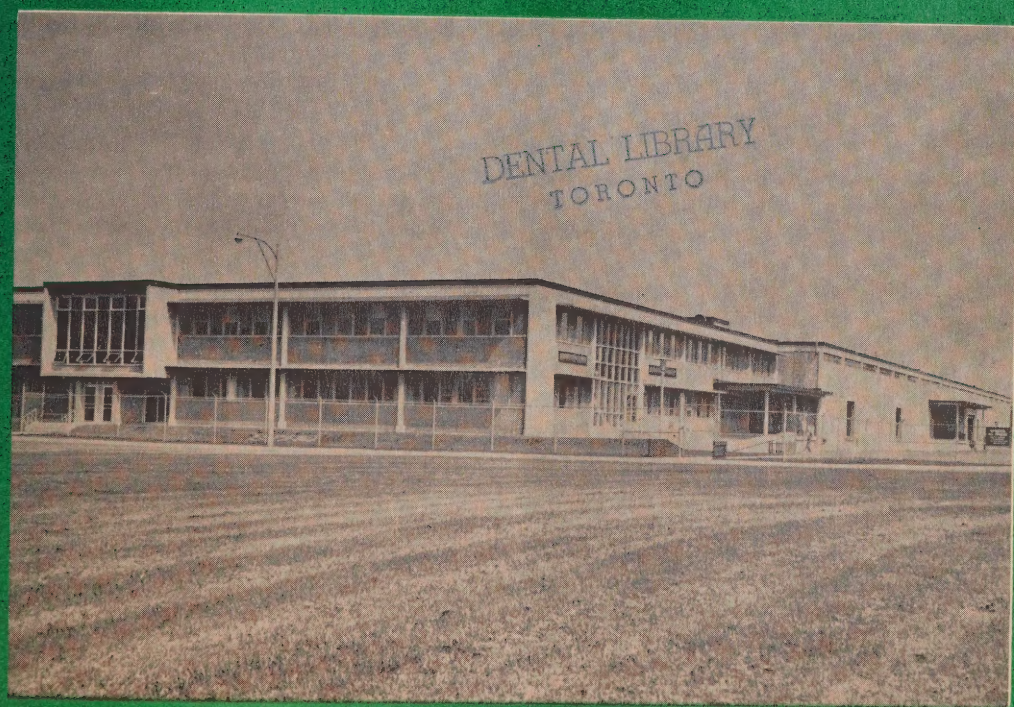
Col JP Whyte, former ADDS Prairie Command and currently Honorary Colonel of the 14th Canadian Hussars, recently held a passing out ceremony in the Swift Current Armoury for the second special militia class. After the march past, inspection and demonstration on national survival techniques, Col Whyte addressed the "ambassadors of survival" with an inspiring speech on the Militia's role in national survival operations.

Pictured below is Col Whyte (left) receiving the rescue helmet and gold efficiency cord from Major IG Clifton, the second in command of the Hussars. At this time the Colonel was made honorary captain of the rescue squad.



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The
**ROYAL CANADIAN
DENTAL CORPS**
Quarterly



VOLUME 3 NUMBER 2

JULY 1962

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THE RCDC QUARTERLY

Published by authority of Brigadier KM Baird, Director
General of Dental Services for the Canadian Forces

Editorial Board: Col GB Shillington
Lt Col GR Covey
Lt Col DH Hillier

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SUBSCRIPTION RATES

The RCDC Quarterly may be subscribed for at \$4.00 per
year by writing to:

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for the Canadian Forces
Army Headquarters,
Ottawa, Ontario.

Cover Photo - No 1 Dental Equipment Depot, Camp Petawawa

E D I T O R I A L

This issue of the Quarterly contains the final report on the Study on Topical Application of Stannous Fluoride which has been in progress for the past three and one-half years and for which the author is deserving of the highest praise. His initiative, energy and perseverance in organizing and carrying this study to completion can only be appreciated by those who have been in association with him during the period involved. There were many others too, without whose co-operation the project would never have matured to its present status. The goodwill and help of the staff of the Royal Military College where the investigation was carried out, the willingness of the Officer Cadets themselves, the cheerful and effective assistance provided by other dental officers and by dental auxiliary personnel during the clinical phases and in the installation and removal of special equipment, all made material contributions to the success of the endeavour. It was indeed a most creditable team effort but primary recognition must go, of course, to the author, Major D.H. Protheroe.

As a result of the report, this procedure has been accepted by the Corps for implementation on as wide a scale as practical. Initially the principal target will be all recruits in the Canadian Forces but ultimately it is hoped to extend the benefits to any member within the proper age bracket. The additional commitment to our already heavy treatment load and the fact that a percentage of those receiving the protection will be lost to the Forces through normal wastage are complications which must inevitably ensue and be accepted. Nevertheless, we are reasonably assured that such sound preventive dentistry will prove to be an economical and rewarding method of attaining one of our main objectives. It is also a cogent means by which our auxiliary personnel can demonstrate more plainly their worth as members of the dental health team.

It is gratifying to be able to present in our own publication a report of this calibre, produced from within RCDC resources. A standard has been set thereby, which should serve us admirably as a guide in the future.

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NO 1 DENTAL EQUIPMENT DEPOT RCDC

Major JW Fletcher, CD

No 1 Dental Equipment Depot celebrates its second anniversary in Camp Petawawa on 17 Jul 62. Since it is impossible for all members of the RCDC to visit the new Depot, the following article has been written in an effort to acquaint members of the Corps with the history of the unit and the present day composition and functions of the Depot.

HISTORY

The pre-war Canadian Army Dental Corps was disbanded on 30 Aug 39 and effective the following day, by General Order 148, was re-organized as the Canadian Dental Corps. This re-organization authorized a Corps HQ including a stores section and one dental company for each of the eleven Military Districts.

The Corps HQ was temporarily allotted four rooms in the old Elgin Building in Ottawa. One of these rooms was used for the stores section and thus the birth of the "Depot to be" took place. It is recorded that this room not only contained samples of trunks and field chairs but also served as an office for the second-in-command, the records officer, the quartermaster, the quartermaster-sergeant, two storemen and a clerk.

The obvious need for more suitable accommodation for all sections at Headquarters continued until eventually the second floor of the old Elgin Annex Building in Ottawa was allotted to the CDC to accommodate the rapidly-expanding stores section. Although the Elgin Annex was an old building with a floor that sagged under the weight of the many dental kits being prepared for issue, it was from this location that the first issue of dental stores was made.

The stores section remained in the Elgin Annex until the winter of 1945 at which time it was moved to the National Grocers Building on York Street in Ottawa. This accommodation, although found to be superior to that of the Elgin Annex, was far from ideal for a stores depot. Thus, in the latter part of 1946, when empty "H" huts became available at RCAF Rockcliffe the depot on York Street was moved to RCAF Station Rockcliffe. Here, under adverse conditions, a proper depot was set up and functioned as such until 1947 when it was moved to Plouffe Park to occupy the space made available by No 26 Central Ordnance Depot RCOC. Here, on 16 Dec 53, the title of the unit was changed from No 1 Central Dental Stores to No 1 Dental Equipment Depot. In 1957, plans were prepared, approved and funds allotted for a new depot in Camp Petawawa which would house both No 1 Dental Equipment Depot and No 1 Central Medical Equipment Depot. By 18 Jul 60 the building had been completed and the depot was officially relocated in Camp Petawawa, some 100 miles up the Ottawa Valley (cover photo). Twenty tractor-trailer loads with 6203 pieces of equipment and supplies weighing about 400,000 pounds had been moved with breakage and losses amounting to only thirty-five dollars--quite an achievement!

DEPOT FUNCTIONS

It should be pointed out that the primary functions of the depot did not change with the move to Camp Petawawa and for the benefit of those who may not be familiar with them, they are listed hereunder.

- a. inspecting, receiving, maintaining, accounting and issuing of dental stores;
- b. repairing unserviceable dental equipment;
- c. conducting courses, trades tests and assessments relating to the trades of Dental Storemen and Dental Equipment Repairers; and
- d. familiarization training on new dental equipment.

The move to a military camp, however, did result in the unit's being involved in a great deal more administration as well as personnel being required to participate in camp and community activities. At first this was found to be quite a change from Ottawa but most personnel soon realized that this was part of the routine in a military camp.

DEPOT ORGANIZATION

To perform the functions previously outlined, the depot is divided into three sections; the headquarters section, which looks after the unit administration, the stores section, which handles all matters pertaining to stores and the training of dental storemen, and the technical repair section which looks after the repair of equipment and the training of dental equipment repairers.

STAFF NO 1 DENTAL EQUIPMENT DEPOT 1962



Front Row: L to R: Thelma Gendron, Rita Little, Ssgt AF Davison, WO1 WD Morris, Lt EA Church, Maj JW Fletcher, Lt M Kostyniuk, WO1 VO Bergland, Ssgt JW Hutchinson, Helen Boisvert.

Back Row: L to R: Sgt A Tait, Mr Luke Faught, Cpl EA Duve, Cpl DT McRoberts, Pte H Snutch, Pte HE Lubitz, Cpl PJ Dumas, Mr Bob Mills, Pte LJP Nadeau, Ssgt TW Sullivan, Cpl ES Beattie, Mr M Dick.

HEADQUARTERS SECTION

The headquarters section, on moving to the new location, assumed the responsibility for publishing unit Part 2 Orders and maintaining personnel records and files. These functions were previously performed for the unit by 1 AAU in Ottawa. Camp administration also added greatly to the duties of this section.

STORES SECTION

Following the move to the new location, the stores section was the first to be set up so that issues could be made without undue delay. Furthermore, a repackaging programme was instituted because of limited height in the warehouse coupled with the acquisition of new metal bins and shelves. During the past two years, the following is a resumé of issues and shipments handled by this section.

Number of accountable items issued - 1,476,081

Cost of issues - \$613,664.34

Value of stock on hand as of 31 Mar 62 - \$552,202.26

Number of incoming and outgoing shipments handled - 2689

Number of pieces in shipments - 18,997

Total tonnage handled - 359 tons.

In addition to the issue and receipt of dental stores, the stores section was involved in preparing the syllabus and conducting the dental storeman group 1 course which was held 16 Oct to 24 Nov 61 with six candidates in attendance. This was the first dental storeman course to be conducted by the RCDC. Since the RCDC is now responsible for the training of dental storemen it is a function of this depot to conduct the group 1 and group 3 storemen courses along with the preparation of group 2 trades tests.



Shipping Section - L to R: Sgt Sullivan, WO1 Bergland, Mr Dick

TECHNICAL REPAIR SECTION

This section is responsible for the repair of all equipment which is beyond the capability of equipment repair at Dental Company level. In addition, personnel of this section are given special projects for development, modification, design and in some cases, manufacture of items of equipment. Furthermore, they carry the bulk of the training load of this unit, not only for all

Dental Equipment Repairer courses but also for instruction on minor maintenance procedures for dental storemen courses. They assess potential DERs and conduct on-the-job training for their junior tradesmen. To add to these responsibilities, the repair of dental equipment in the Ottawa area as well as the repair of equipment in clinics in Camp Petawawa, Ont, Foymount, Ont and Falconbridge, Ont has been delegated to this section.



Training Section Equipment Repair
L to R: Lt Church, Cpl Duve

TRAINING

Training has become an integral part of the operation of this unit since its move to Camp Petawawa.

The following special to corps courses have been conducted up to the present time:

1 Dental Equipment Repairer Gp 1	-	12 Sep to 21 Oct 60
1 Dental Equipment Repairer Gp 2	-	5 Sep to 15 Dec 61
1 Dental Equipment Repairer Gp 3	-	24 Oct to 16 Dec 60
1 Dental Storeman Gp 1	-	16 Oct to 24 Nov 61

In addition, approval has been granted to conduct one Dental Equipment Repairer Gp 1 course, one Dental Storeman Gp 1 and one Dental Storeman Gp 3 course during the training year 1962-63. Although the training load is not heavy, the courses syllabi require annual review as a result of new equipment being adopted and new techniques introduced.

Unit training is required and involves National Survival and First Aid training along with annual pistol qualification for officers, all of which is normally taken with 1 CMED. Numerous courses are held each year under Camp arrangements and, time permitting, personnel are authorized to attend. Examples of courses available are: French Language training, Life Guard courses, Advanced First Aid, Hunter Safety courses and other refresher training courses. One officer from this unit was fortunate enough to be authorized to attend a five-day training programme at the factory of the Midwest Dental Manufacturing Co in Chicago.

CAMP DUTIES

Camp parades and inspections are regular but not too numerous. Similarly, duties such as Camp Field Officer, National Survival Duty Officer, HQ Camp Inspecting Officer, HQ Camp Orderly Sergeant have to be performed regularly. Depot personnel were hesitant about these duties at first but have become accustomed to them and can carry out these tasks with the best of them.

In a semi-isolated camp such as this, community activities are of prime importance. Since all the service personnel of the unit, except one, are living in permanent married quarters, the requirement for leadership and assistance in these matters is realized, and at the present time fifty percent of the personnel are involved in some community activity. Added to this are numerous social functions which begin in the fall and terminate in the spring. From all reports most personnel attend and enjoy this "social whirl".

As far as sports are concerned, the depot has always been well represented in Camp Petawawa. The past two years have been extremely good for dentals in both the curling and bowling circles. However, other sports ranging from golf to scuba diving to judo have been participated in with distinction by personnel of the unit.

CAMP PETAWAWA - PAST AND PRESENT

In conclusion, it may be said that all personnel of this unit agree that the Camp Petawawa of today is not the same Camp Petawawa of years gone by. Temporary buildings and tents in this semi-isolated area have been replaced by modern permanent buildings which include a shopping centre and a recreational building. Personnel are able to participate in almost any past time. The area is conceded to be a fisherman's and hunter's paradise, but no matter what the hobby might be, facilities are available. Certainly, it takes one who has been moved from a larger centre a few months to adjust to the semi-isolation but thereafter the usual comment heard is that it is good to get away from the smog and the heavy traffic of a larger community. What could be more desirable than a new depot in which to work, adequate married quarters, all the community activities available at a modest expense and the camaraderie and esprit de corps which exist at 1 Dental Equipment Depot, Camp Petawawa!

The following is an extract from the Governors' Letter, Volume 10, Number 16 dated May 29, 1962:

Fluoridation in Canada, 1962

In January 1962, 8.4 per cent of Canada's population was living in communities with controlled fluoridation. This represents 1,535,000 people living in 87 cities, towns and villages. Twenty-five more communities are fluoridating their water supplies now than at the same time last year. Fourteen of these 25 are in Saskatchewan, six in Quebec, three in Ontario and two in the Yukon and Northwest Territories.

A total of 37 plebiscites was held during 1961. Of these only 15 were successful, five out of 16 in Ontario, seven out of 13 in Alberta, one out of six in British Columbia and one out of one in Saskatchewan and the Northwest Territories.

Major-General H. Quinlan, CB, QHDS
 Director of Army Dental Service
 Royal Army Dental Corps



THE BRITISH ARMY DENTAL SERVICE

It may be claimed that the foundations of Army dentistry were laid in the very corner-stone of the structure of the Army itself. Charles I, who was the first monarch to institute an Army as a regular force, ordained that a free issue of surgical instruments should be made available to the surgeons he was trying to induce to accompany the expeditionary force he raised against the French. Included in the issue were instruments of dental origin. From their shape and size it can be deduced that scaling and treatment of the gums were accepted forms of dental treatment at that time.

It took 300 years more before military dentistry was placed on an organised footing. It was not until 1921 that dental treatment was acknowledged as an essential contribution, but came to be accepted as a vital necessity for the preservation of the health of the soldier both in peace and in war.

Despite the experiences of the South African War and even as comparatively recently as the outbreak of the 1914-18 War, little or no provision was made for dental treatment for the British Forces.

The story goes that it was not until the Commander-in-Chief of the B.E.F., who in the early days of the first world war, himself became stricken with an acute dental malady and being unable to find anybody to relieve him, had to have recourse to summoning a dentist from Paris to alleviate the pain.

Included in subsequent despatches to the War Office, the C-in-C represented these matters with such vigour that by the end of 1914 a dozen or so dental surgeons were induced to leave their practices and put on uniform. They were hastily commissioned as "Dental Surgeons, attached General List" as doctors only were accepted for Commissions in the RAMC. The General List contained a conglomeration of officers and other ranks who did not readily fit into any of the existing Corps or Regiments but for whom a niche had to be found in their role as support for the Army. Throughout the period of the war the numbers of dental officers gradually increased until at the conclusion of hostilities over 850 dental surgeons were serving in all theatres at home and overseas.

Though the beginnings of Army dentistry on an organised basis are comparatively modern, that there were other influences in earlier times which had some bearing on dental standards are now history. John Woodall, first Surgeon-General to the East India Company, described how scaling and gum treatment in addition to extractions were performed. There is also mention in his writings of extensive caries with cellulitis of the face and facial angina as complications of acute alveolar abscess.

Richard Wiseman recorded in the year 1676 how treatment of a gun shot wound sustained by a soldier, was treated with a prosthetic appliance to assist closure of the wound involving the antrum.

Curious to relate, too, is the introduction of a dental standard for soldiers at about that time though this had nothing to do with dental fitness or ability to masticate or articulate. It was introduced only for the reasons that it was essential to ensure that musketeers and grenadiers had sufficiently sound incisor teeth to bite open their cartridges and grenades before firing.

A general medical examination for recruits was introduced towards the end of the 18th century but it took another century before recruits came to be rejected solely on account of dental disability on the grounds of having insufficient sound or repairable teeth for efficient mastication. This was the standard required before the 1939-45 War.

When the South African War broke out in 1899 no dental attention was provided for the soldier. The numbers incapacitated from dental disabilities, though completely disregarded by the military authorities, did not escape the vigilance of the British Dental Association. Their constant representations to the Secretary of State for War caused him, in the end, to make at least a token gesture by sending four civilian dentists to South Africa. They were given no military status and were not provided with either instruments or materials. Such instruments as they carried came from their own private resources.

Recruiting flourished and volunteers were plentiful. It gave rise to little comment that in the South African campaign 2,000 soldiers were evacuated home and nearly 5,000 found unfit for duty on the grounds of dental disability alone. It would hardly seem possible that such a lesson could escape the notice of the War Office because it was not until some years later that, as a result of further pressure from the B.D.A., it was agreed somewhat reluctantly to appoint 8 dental surgeons to the Army at home. These appointments similarly carried no military rank or status and the scope and extent of treatment they were permitted to afford was severely circumscribed. It amounted to little more than the urgent treatment for the relief of pain. Later, three further appointments were offered to civilian dental practitioners

to go out to India to minister to the dental needs of the British soldiers serving in that country. One of the practitioners who took up a contract of this kind was J.P. Helliwell, later Major-General Helliwell who became the first Director of the Army Dental Service.

Meanwhile, upon the re-organisation of the Army Medical Services, dentistry was one of the subjects in which RAMC officers could be graded as specialists. Only four were so graded but as they were not given either the time or the opportunity to work in their specialty, the scheme was soon abandoned.

It is no wonder that when war broke out in 1914 the facilities for dental treatment were meagre in the extreme. No provision was made for treatment in the field and not a single dental surgeon could be numbered among the "Old Contemptibles" of the BEF who went to France.

It was not until the last two years of the war that dentistry was really accepted, given full recognition and assumed its rightful place in the Army, though the actual formation of an Army Dental Corps was delayed until well after the cessation of hostilities. Special Army Order No. 4 dated 11th January, 1921 promulgated the formation of a Corps to be known as "The Army Dental Corps".

The Corps charter was to provide dental treatment for the Army and the Royal Air Force but the latter in 1930 formed its own separate Dental Branch as part of the RAF.

The new Corps had an establishment of 110 officers and 132 other ranks which seemed hardly sufficient to deal with the backlog of dental disease for Army personnel, even though dependants and officers were not included. It was decided therefore to give priority treatment to recruits and to devote the maximum effort to improving the dental standard of the youngest soldiers of the future Army.

This aim was largely achieved because by 1938 every recruit on completion of his initial military training, before he was posted to his battalion from the Regimental Depot, had to have all dental treatment completed. Consequently, further treatment was required on a maintenance basis only. With an annual inspection in addition, the standard of dental fitness in the Army was extremely high.

The years between the wars provided a period of steady development of the Corps within the Army structure. The activities of the Army Dental Corps became well known professionally, militarily and in other fields. Officers and other ranks of the Corps were "capped" for the Army at cricket, tennis, hockey, swimming, Rugby and Association football. International honours at some of these games were also achieved by Corps members. Wherever British troops served, there also were to be found representatives of the Corps.

With the call-up of the Militia in 1938 and general mobilisation in 1939 the strength of the Army grew enormously. The serious wastage of man power through dental disease was by now well appreciated. In general the dental state of the expanded Army, apart from the Regular soldiers, was deplorable and the Corps augmented by dental officers of the Regular and Territorial Army Reserve of Officers faced a task of the greatest magnitude.

When conscription was enforced a Dental War Committee was formed and given powers which included drafting dental surgeons, technicians and clerks to the Services. During the course of the War the strength of the Corps quickly grew to 2143 officers and 3653 other ranks. Later 267 women of the Auxiliary Territorial Forces reinforced the dental clerk section of the Corps.

Dental personnel worked in static Dental Centres at home and overseas, in field and static hospitals, convalescent depots, casualty clearing stations and field ambulances, in self-propelled mobile dental vehicles and even in suitably adapted trucks. In temperate climates and in the tropics, in jungle and in the desert, the dental officer and his team were available everywhere.

The expansion of the Army and the expectation of widespread casualties led to the establishment of a specialist service for the treatment of unusual dental lesions and maxillo-facial wounds and injuries.

The appointment of a Consultant Dental Surgeon to the Army was made. Dental officers with special experience and skill were selected for posts in general hospitals and casualty clearing stations to whom patients, suffering from conditions beyond the scope of general dental practice, could be sent for diagnosis and treatment.

Further specialisation developed with the formation of specialised units known as Maxillo-Facial Units. Here the dental officer and his dental technician had a most important role to fill. Working alongside the plastic surgeon and the other medical and nursing personnel engaged in the repair and treatment of maxillo-facial wounds, their role became increasingly important.

With the increase in the numbers of Dental Corps personnel serving with the Army the rate of casualties increased also. Apart from the sick, wounded and those killed, a considerable number remained as prisoners of war throughout the period of hostilities.

It was in some of these prisoner of war camps that the officers of the Corps performed some of their finest and most ingenious forms of treatment. Teeth were filled with raw rubber and resin from the bark of trees, hypnosis was frequently employed when anaesthetics were unavailable. Chairs were constructed from bamboo and rope. One of the earliest escape stories of the war took place from a P.O.W. Camp and concerned a Lance Corporal of the Corps who made his way from Poland to England by a devious route. His bravery and ingenuity culminated in his being decorated with the Distinguished Conduct Medal.

While the Army Dental Corps was responsible for the treatment of the Army in India, the enormous increase in the number of British troops in that theatre together with the unprecedented expansion of the Indian Army led to the formation of the Indian Army Dental Corps. With their colleagues in the Army Dental Corps the personnel of the I.A.D.C. were to be found in every theatre where the Indian Army was deployed.

With the conclusion of the hostilities, demobilisation and retrenchment in 1945 brought their attendant troubles. Those who had so gallantly answered the call by giving up their practices and joining the Corps, returned to civil life to once again pick up the threads. Those officers who had survived and who had been in the Corps in pre-war days were compulsorily retained and conscription in the guise of National Service was to become a permanent feature of peace time life.

The call-up of dentists was placed in the hands of the Ministry of Labour and a Dental Manpower Committee was introduced to whom appeals against compulsory service was addressed. These appeals were fortunately few, the National Service men accepted their obligations. With their colleagues in the Regular Corps they continued to provide a comprehensive dental service for the Army and its dependants.

In the light of experience and the place and prestige dentistry had gained for itself in the public eye during the War, the re-organisation and improvements in the Corps which followed, were a natural sequence. The appointment of the first Honorary Dental Surgeon to the Sovereign was made when Major-General A.B. Austin became K.H.D.S. and to the title of the Corps was added the prefix Royal. The Corps insignia was changed from the intertwined A.D.C. to a heraldic dragon's head and sword, surmounted by a crown, the whole surrounded by a laurel wreath above the inscription "Ex dentibus ensis". The formation of a home for the Corps at Connaught Barracks, Aldershot, by the establishment of the Depot RADC and the RADC Headquarters Officers' Mess at that location helped to give permanence and place the Corps on a firm foundation as an integral unit of the Army.

There are many advantages of service in the Corps today. First of all there is great emphasis on the professional side. Re-equipment and refurnishing on the most modern and up-to-date lines together with new accommodation, especially designed, is rapidly proceeding. Professional refresher courses, for which the War Department pays, at post-graduate hospitals and institutions are widely available for all officers. There is complete clinical freedom and for the officer who wants to take higher post-graduate diplomas and degrees there is ample opportunity for study leave and extramural courses leading to the highest academic attainments in the profession. These are some of the facilities available in the Army Dental Service today.

Army cadetships leading to permanent commissions in the Royal Army Dental Corps, are now available to school leavers who wish to take up dentistry as a career and be granted permanent commissions in the Corps. There is also a modified scheme available to students who are in their last two years at university and who wish to be appointed to permanent or short service commissions. In addition to paying all tuition fees and the provision of all books, instruments, white coats etc, the War Department allows a generous scale of pay and allowances to those students who are accepted for cadetships.

If married an officer becomes eligible for married quarters at the age of 25. Accommodation for himself and his family are provided at most stations to which he is liable to be sent. Schools for his children are available overseas and boarding school allowances are available to assist with school fees.

In addition to providing the courses and training for grading as specialists, officers so appointed are given extra pay according to their specialist status.

With the steadily rising rate of pay throughout his service the officer on a full career will almost certainly be better off than his civilian counterpart who, for one thing, usually has to expect diminishing returns in earnings in the later years of practice. The Army dental officer on the other hand has not only healthy financial, steadily increasing rewards during his service but on retirement he has a non-contributory pension plus a lump sum terminal gratuity to which he can look forward. It might also be mentioned that the widows of officers are not altogether forgotten and are eligible for the grant of a pension should their husbands predecease them.

It should be made absolutely clear that there is no compulsion, except for officers who join as cadets, to serve in the Army for a longer period than the officer wishes. Tax-free gratuities are given to those who serve for less than 16 years which is the minimum period for pension rights to become operative.

Dentistry can be a confining and restricting form of career. For those men and women who may be attracted to either a hospital or a general practice career in the profession and who might consider the benefits of a periodic change of environment, or locality or even the surgery itself, the Army Dental Service provides this source of refreshment. Coupled with the facilities for comradeship, sociability, sport and travel a fuller and more satisfying life can be achieved away from the worries and frustrations of private practice.

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DENTAL ASSISTANT TRAINING IN THE RCDC

Colonel CE Purdy, CD, DDS
Commander RR Troxell, (DC) USN

A series of experimental studies was recently conducted at The RCDC School with the aim of devising an effective method for the rapid training of new dental assistants. The programme was designed to achieve maximum assistant function in one week with minimal interruption to the normal schedule of the training dental officer.

This study has resulted in the creation of a supplemental training programme which is intended to serve the following functions:

- a. Provide an effective means of assessment of potential dental assistants in a minimum period of time.
- b. Be a guide to the rapid training of untrained assistants who are required for chair-side duties prior to formal training.

Background and Rationale

In the past, new recruits and others who were allocated to or transferred to the RCDC, have been assigned to certain clinics for orientation and initial in-job training before attending the formal trade course at The RCDC School. However, the degree to which they were trained at the chair depended largely on the discretion and requirement of the dental officer and on the time available. It was recognized that an early evaluation of their capabilities and potential value as assistants has been difficult.

It was also recognized that situations arise in which a dental officer may be temporarily deprived of the services of his trained assistant. Sudden illness, compassionate leave or a debilitating accident, could create such a situation.

The problem thus posed was: In how short a time could an untrained person be brought to a level of reasonable efficiency at the chair, without interrupting the regular schedule of the dental officer?

The hypothesis was that if -

- a. Careful analysis in selecting the absolutely essential functions of dental assisting and,

- b. All initial training efforts could be concentrated upon those essentials, then, a very brief period of training might achieve the necessary results.

The analysis produced the following:

The Absolute Essentials for the Dental Assistant

- a. Must have the following qualities:

- (1) Average intelligence.
- (2) A neat, well-groomed appearance.
- (3) A properly motivated attitude to correct office protocol.
- (4) A high sense of loyalty.

- b. Must know proper methods for:

- (1) Careful handling of delicate, expensive dental instruments.
- (2) Maintenance of handpieces.
- (3) Rapid clearing of the operatory between patients.
- (4) Instrument sterilization and maintenance of sterility.
- (5) Chair-side attendance.
- (6) Delivery of anesthetic syringe.
- (7) Presentation of routine instruments for any given operation.
- (8) Processing of radiographs.
- (9) Presentation of prepared amalgam.
- (10) Passing amalgam and necessary instruments.
- (11) Presentation of prepared silicate cements.
- (12) Set-up of silicate finishing instruments.
- (13) Presentation of prepared basing materials.
- (14) Pouring and recovery of models.
- (15) Completion of dental records.
- (16) Telephone etiquette.
- (17) Maintenance of office supply levels.
- (18) Meeting office emergencies without panic.

The next question posed was: Which of the essentials from the "must know" list could be postponed during the early stages of training? It was decided that items 1 through 13 would be required in order for the trainee to be effective at the earliest possible time.

How would the training programme actually be conducted? How long would the training program last? How would appropriate emphasis be placed upon the essential matters?

Pilot Study

A pilot study was designed and conducted in the following manner in order to evaluate the hypothesis.

On a Friday evening, a dental officer, assigned to the Treatment Wing of The RCDC School, was informed that starting on the following Monday morning, he would be assisted by a totally untrained and untutored soldier instead of his regular dental assistant.

The dental officer was to see and render treatment to all patients in accordance with his previously established appointment calendar. The only variation which he was to permit himself, was to undertake fewer operations per patient than he normally would. The time thus saved would be used to demonstrate instrument cleaning, sterilization and other procedures.

Each procedure usually performed by a trained dental assistant such as mixing of amalgam, cements, alginates, and other materials was to be performed by the dental officer as a demonstration for the trainee, until the trainee could perform these by himself.

Strong emphasis was to be placed upon the rapid clearing of the operating bay between patients, in order that the appointment schedule be maintained, and each patient received on time.

The dental officer was to jot down the names of items and a few comments about important subjects after he had demonstrated them. This would serve the trainee as a set of "lecture notes" for the evening study or review.

Evaluation of the Pilot Study

The pilot study was conducted for the period of one working week. It was then evaluated. The following conclusions emerged:

- a. The trainee had achieved a reasonable level of effectiveness.
- b. The trainee was fatigued but willing to continue as a dental assistant.
- c. The dental officer was fatigued but gratified at the results achieved.
- d. The programme required additional organization and planning.
- e. The "lecture notes" technique was unsatisfactory.
- f. The hypothesis that concentration on essential functions and the exclusion of non-essential functions or knowledge was valid.

Preparation for Further Studies

In order to give added organization to the programme, minimize fatigue of the training officer, give the trainee additional motivation, thereby maintaining his interest, a series of study notes was prepared. This consisted of six lessons of approximately ten pages each of double-spaced lines. These were to be given to the trainee, one at a time, each night of the training week with the exception of the first one which was to be given on the Friday preceding the week's training. The first lesson was a general introduction to the programme, and a description of the equipment which the trainee would see in the office. The other lessons or information sheets, as they are labelled, were designed to serve two purposes: first, they were to review material which the dental officer had demonstrated, in such way that the trainee would remember salient features of all essential office procedures; second, they were to serve as a guide-line to the officer, in his instruction to the trainee.

Further Studies

With these sheets prepared, additional trainees were carried through one-week training programmes and the sheets used as described. The sheets were modified, and additions made as the need became apparent.

Evaluation of Studies

The conclusions reached by evaluation of the final training programmes conducted, were:

- a. The information sheets greatly reduced the fatigue, time and effort of the training officer.
- b. The sheets offered an organized presentation of material, which permitted the trainee to assimilate demonstrated information, and to retain it well.
- c. The sheets were of great assistance to the dental officer in presenting the material in an organized manner.

Conclusion

A one-week training period, as described, will produce an effective chair-side assistant, or permit assessment of the capabilities of a potential transferee to the Corps.

The information sheets referred to are to be made available for general use in the RCDC as a pre-course training for dental assistants.

Dr Lussier Heads Dental Faculty at University of Montreal

Sincere congratulations are expressed by all members of the RCDC to Dr Jean-Paul Lussier, DDS, PhD on his recent appointment as Dean of the Faculty of Dentistry, University of Montreal.

He has been Vice Dean and Director of Studies at the University of Montreal since 1957 and accepted the appointment of Consultant to the RCDC on Dental Research in Feb 1960. Dr Lussier is also a member of the National Research Board and a Fellow of the American College of Dentists.

MAT GOLD AS A RESTORATIVE MATERIAL

Commander RR Troxell^{*}
Dental Corps
United States Navy

During the past decade, a great resurgence of interest in gold foil restorations has occurred throughout the dental profession in North America. This interest has been made manifest in a number of ways. The programme of almost every major Dental Convention, in the last few years, has included at least one eminent clinician who has spoken upon the employment of gold foil or foil-type restorations. The membership of the American Academy of Gold Foil Operators has increased from an organizational 36 in 1952 to more than 400 in 1961. The quantities of rubber dam and cohesive golds purchased by the profession has more than doubled since 1955.

Why has this resurgence occurred? First and foremost, because a number of dedicated practitioners have demonstrated by example that cohesive gold restorations do have a significant place in the busiest, most modern dental office. They have demonstrated that a dentally educated public is not only willing, but eager to receive the finest restorative dentistry that the profession can offer. They have developed new techniques which simplify and expedite the placement of cohesive restorations, so that many dentists once avoiding foil because of the considered tedium of insertion, are now able to achieve the best in markedly less operating time.

It is quite interesting to note that one of the primary reasons for the entire phenomenon of re-awakened interest has been the development of a combination filling technique for the class V cavity.¹ A lesion located in the class V area offers challenges peculiar to itself. A true restoration in this area must re-establish the convexity of contour characteristic of the cemento-enamel junction; and the material used must be capable of receiving and holding a finish which will be beneficial to the gingival tissue.

It is generally recognized that the plastic filling materials (amalgam, silicate, acrylic) are difficult to contour properly in the class V location; and that even if properly contoured during placement and carving, they are frequently undercontoured during polishing. On the other hand, gold foil, because of its cohesive character, may readily be excessively contoured during placement and then reduced to ideal contour during finishing and polishing. The necessity for an anatomic convexity of a class V restoration is unarguable. It is a physiologic verity that gingival tissue will recede from a labial or buccal gingival concavity on a tooth, or even from a gingival plane surface; conversely, gingival tissue will tend to rise up over a truly anatomic cemento-enamel junction.

Silver amalgam is a remarkable and highly effective restorative material when manipulated in accordance with a few cardinal principles. However, in operative situations where the possibility of violation of one or more of those principles exist, then it is not the material of choice, that is to say, if amalgam may not be packed with sufficient pressure to create homogeneity of its mass, then it will be mercury-rich and granular. Having no malleability, no amount of subsequent manipulation of its surface will create a finish which is acceptable to gingival tissue. All too frequently, the class V cavity presents just such a situation. Heavy packing pressure at one point forces the amalgam out of the cavity at another. To correct this, the operator reduces the amount of packing pressure used. Sometimes the amount of pressure used is no greater than a "buttering" stroke.

^{*} (on exchange duty at The RCDC School)

The use of cohesive gold as a permanent restorative material, is therefore frequently indicated. It was recognized that the placement of gold foil by itself is a time-consuming and tedious procedure for many operators. The combination technique employing mat gold with gold foil was developed to overcome those disadvantages.

Character of Mat Gold

Mat gold is formed by a process of electrodeposition. An ingot of gold is placed in a bath, and by electrolysis, particles of the ingot are deposited upon the floor of the bath. When a sufficient thickness of the deposited particles has been achieved, the bath is drained, the "mat" of gold is recovered, molded, heat treated, and cut into various widths. As received in the dental office, mat gold is a crystalline deposit of gold 999.999 fine, which is cohesive by virtue of its purity. It has a dull, spongy appearance and is yellow-brown in colour. It compacts readily with pressure delivered by a hand-plugger. As might be expected of a pure, highly malleable metal, it has no "memory" and does not spring back following compression. Because of its crystalline form, an explorer or a small plugger point will penetrate it easily, simply by pushing the crystals aside during penetration. Therefore, during manipulation, relatively large round-edged pluggers are used.

Mat gold in its compacted form has less homogeneity than has gold foil, because of the malleting used to produce the foil or leaf form during manufacture.

It seemed desirable to develop a technique which would couple the advantages of each of the two forms of pure gold (the facile compacting ability of the mat, and the extreme compressibility and density of the foil). Such a technique was developed wherein the bulk of the cavity is rapidly filled with mat, and then a veneer of foil completes the filling of the cavity and seals the margins.

Combination Technique for a Class V Cohesive Gold Restoration

Careful and prolonged study revealed that the trapezoidal Ferrier cavity preparation offered several significant advantages over the classic "kidney" shape preparation. With the Ferrier preparation, the mesial and distal cavo-surface angles could be carried around the mesial and distal line angles of the tooth and thereby be placed beneath the free margin of gingivae. The gingival cavo-surface angle could be greatly reduced in width and invariably placed beneath the free margin of gingival tissue. The mesial and distal walls could be flared from internal to external in order to follow the direction of the enamel rods and preclude weakening either of those walls. Additionally it was discovered that the straight occlusal cavo-surface angle rendered a more pleasing appearance in a mouth in which a number of class V restorations had been placed.

Cavity Preparation

A rubber dam is placed and the Ferrier #212 clamp is seated upon the carious tooth. The clamp is so positioned as to retract the tissue gingivally, and to hold the inverted rubber dam in such position that it retracts the gingivae mesially and distally. The bows of the clamp are supported with low-fusing compound and the clamp thereby stabilized. The clamp should be sufficiently supported that it may serve as a finger-rest during instrumentation. The cavity is prepared. This preparation has opposing grooves only

in the occlusal and gingival walls as the retentive feature. The proximal walls must not be undercut lest they be weakened. The gingival wall is made narrower than the jaws of the #212 clamp, and the cavo-surface angle of the gingival wall is not closer than $1/2$ mm to the jaws. Should the preparation approach closer than that, the clamp should be resealed.

Filling the Cavity

A number of pieces of mat gold, each the size of the outline form of the cavity are cut. While the mat gold does not require annealing, it must be heated to vaporize any collected moisture. The first piece of mat is carried to the cavity and placed so that it covers the entire floor. It is condensed with hand pressure until forced into all internal line angles. A small-pointed plugger is then used to drive the mat firmly into the occlusal and gingival retentive features. The second piece of mat is placed and condensed with hand pluggers. If the occlusal or gingival retentive features were not filled by condensation of the first piece, the small plugger is again used to fill the opposing retentive features.

As soon as this has been accomplished, the remainder of the bulk of the cavity is filled using only hand-pressure condensation of the mat gold. Hand or automatic malleting of the mat gold (except in the retentive features) is contraindicated, for this would nullify the advantages gained by its use (reduced trauma and rapid filling). Filling by the mat is carried on until only the external portions of the cavo-surface angles of the cavity remain exposed. Then, previously annealed gold foil is malleted to create the veneer of foil over the entire filling. Establishment of slightly excessive contour is accomplished at this stage.

Finishing the Gold

The gold files, push and pull, are perhaps the instruments of choice for completing the contouring and finishing of the restoration. They may be rested upon enamel and gold simultaneously and will quickly reduce any marginal excess, with no damage to the enamel. If the gingival margin is located in cementum, great care must be taken to avoid removal of cementum. The files must not be permitted to rest upon or touch cementum at any stage of the stroke. Frequently it will be found that a pull file used with a pushing action will offer greater control and will create the desired result with surprising ease.

Cuttle-fish or extremely fine sandpaper discs coated with silicate lubricant, may be used for some final contouring, however, they must be used with great care lest contour be lost or cementum removed.

Polishing

Flour of pumice (dampened) in a soft rubber cup will produce a velvet finish to the restoration, which is well tolerated by the tissues. It is a matter of operators' choice whether additional polishing with a finer agent is desirable.

Summary

The class V lesion offers a special restorative problem. Only cohesive gold offers an optimal solution to that problem. Gold foil used alone for the restoration may be considered too time-consuming to be practical. A technique

wherein a combination of cohesive golds are used, which greatly facilitates the placement of the restoration, has been described.

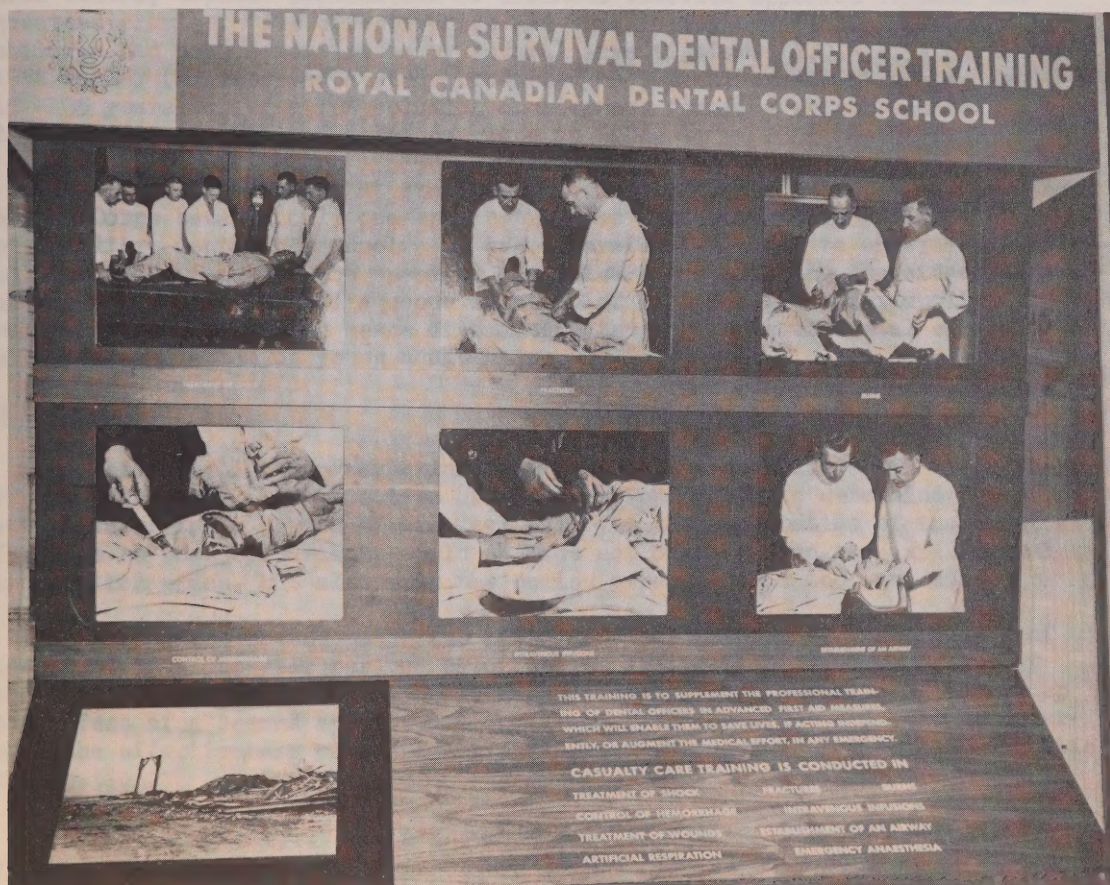
Reference

The referenced article, listed below, offers an excellent step-by-step, illustrated description of the technique. It is highly recommended reading.

1. Koser, J.R. and Ingraham, Rex. "Mat Gold Foil with a Veneer Cohesive Gold Foil Surface for Class V Restorations." J.A.D.A., 52:715, June 1956.

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NEW RCDC EXHIBIT



A most interesting and attractive RCDC exhibit was shown for the first time at the ODA Convention at Toronto in May 62 and later at the CDA Convention at Vancouver. The display, which illustrates the National Survival Dental Officer Training, is available for other conventions or exhibitions on request.

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A STUDY TO DETERMINE THE EFFECT OF TOPICAL APPLICATION OF STANNOUS FLUORIDE ON DENTAL CARIES IN YOUNG ADULTS

Major DH Protheroe, DFC, CD, DDS, MPH

The prevention and control of dental caries in a military population, when the dental service is committed to provide comprehensive treatment, is a problem of enormous proportions. The RCDC, with a large backlog of treatment requirements and limited dental officer resources, is barely able to exceed the requirements imposed by the incidence of new carious lesions, let alone perform sufficient treatment to markedly reduce the backlog. In view of this situation it is obvious that the introduction of a caries-preventive measure which would significantly lower the incidence of dental caries would be of inestimable value to the Corps.

It was considered that, of the various anticariogenic agents that had been tested, topical application of stannous fluoride appeared to hold the greatest promise. Its effectiveness and superiority over sodium fluoride in children had been demonstrated by several investigators (1,2,3,4,5). Then in 1958 Muhler (6) reported a study conducted on 500 university students, aged 18 - 35 years, using a 10% solution of stannous fluoride which resulted in a 24% decrease in DMFT and a 16% decrease in DMFS.

It was also felt that stannous fluoride should be selected for testing by the Corps because only one application was required and it could be applied by auxiliary dental personnel. It was, therefore, decided to undertake a clinical investigation with the specific objective of determining the effectiveness of a freshly prepared 10% aqueous solution of stannous fluoride, applied topically to the teeth, as a means of reducing the incidence of dental caries in a military population of young adult males.

Design

The investigation was originally planned to be conducted in three phases of one year each. The objective of the first phase was to determine the caries attack rates for a period of one year prior to the application of the stannous fluoride so that comparisons could be made not only between the experimental and control sides, but also with the caries experience on the same side.

During the second phase the aim was to determine the effectiveness of the agent in a one-year period following its application. The objective of the third phase was to determine by refluoridization of one-half of the group the effect of a second application one year after the first and also to determine the effectiveness of the agent during the second year following the initial application.

Unfortunately, it was not possible to adhere to this plan completely. Prior to the commencement of the study it had been planned to use two examiners, each of whom would perform one-half of the examinations and re-examine the same subjects throughout the study. However, following the examination at the beginning of phase 1, it was felt that the findings would be more reliable if one examiner performed all the examinations but the other examiner should continue to examine one-half of the subjects even though his findings would not be used, so that he could take over in case of an unexpected posting or other exigency of the service. This, of course meant that the data gathered at the beginning of phase 1 could not be used but the experience gained during this period would be useful during the remainder of the study.

Furthermore, the greatest wastage of study subjects occurred during the first phase when fifteen were lost compared to a total of nine during the remainder of the study.

The second alteration to the original plan was to shorten the duration of phase 3 for the total group from twelve to eight months because of graduation of the senior group. However, the junior group were examined during this phase at eight and fifteen months. It is felt that neither of these changes affected the validity of the results.

Study Group

The study group at the commencement of the study was comprised of 106, 17 - 21 year old first and second year cadets enrolled in Royal Military College, Kingston, Ontario. The first year cadets were designated the junior group and those in second year the senior group. The age distribution of the cadets who completed the study is shown at Table 1. The average age of the total group at the start of the study was 18.8 years, the junior group 18.4 years and the senior group 19.4 years.

TABLE 1

AGE DISTRIBUTION OF STUDY SUBJECTS

Age Last Birthday	Junior Group	Senior Group	Total
17 years	7	-	7
18 years	19	6	25
19 years	17	16	33
20 years	1	6	7
21 years	2	6	8
Total	46	34	80
Mean Age	18.4 yrs	19.4 yrs	18.8 yrs

Method

The stannous fluoride was applied according to Muhler's technique (7) but with a rubber dam in place on the experimental side. This was done because it was felt that the completely dry field afforded through use of the rubber dam might increase the effectiveness of the agent and also would reduce cross-contamination between the experimental and control sides of the mouth. The experimental side of each study subject was randomly selected by flipping a coin. "Heads" indicated the left side and "tails" the right side. All clinical procedures except the oral examinations were performed by RCDC clinical technicians.

Examinations

The clinical examinations included a thorough hard tissue examination with a mirror and No 3 spiral explorer performed under panovision light with compressed air available for drying. In addition, four bitewing radiographs were taken at each examination and the prophylaxis which forms part of the stannous fluoride technique was performed just prior to each examination. As mentioned previously the examinations were performed by two examiners, one of whom examined all of the subjects, the second re-examined one-half so that he could take over in case of an unexpected posting. The radiographic interpretation was carried out following the examination and represented the combined opinion of the two examiners. The examiners were not informed of the experimental and control sides.

Analysis of Data

The statistical procedures recommended by Grainger (8) for clinical dental caries control studies were used to analyse the data obtained in this study.

Data and Discussion

At the beginning of phase 2 a total of 4,962 caries-free surfaces were recorded on the experimental sides and 4,987 on the control sides. Of these, the senior group had 2,145 and 2,140 and the junior group 2,817 and 2,847 on the experimental and control sides respectively. At the same time the caries experience for the total group was 1,509 DMF surfaces on the experimental sides compared to 1,467 on the control sides. This indicates a good balance between the experimental and control sides at the time of the first application of stannous fluoride.

The most important findings of the study are given in tabular form at Appendix "A". Table 1 gives the results using DMF surfaces as the index of caries experience. It may be seen that the average difference in dental caries incidence in favour of the experimental sides during the first year following application of the agent (phase 2) was sizeable (54.0%) and statistically highly significant.* However, during the third phase, a period of eight months at the beginning of which the junior group only received a second application of stannous fluoride, the average reduction was less (25.7%) and not significant.

The accumulated results of phase 2 and phase 3 are interesting to note. The total group during this period of 20 months showed an average reduction in DMFS of 45.3%. When the junior group only, was considered over a period of 27 months, the reduction averaged 38.8%. The reductions shown in tables 2 and 3, with new lesions as the index of caries experience, are similar.

The proportions of sides remaining caries-free shown in table 4 show a similar result. During the first 12 months following the initial application (phase 2) the additional percentage of experimental sides remaining caries-free above that found in the control sides was in the range 5.6% to 34.1% (significant);

* Note: Significance as used here denotes the probability of the difference being a chance occurrence. An observed difference is considered "highly significant" if the probability of it occurring by chance is less than one in one hundred and "significant" when the probability is less than one in twenty.

and during phase 3 it dropped to -12.0% to 19.6% which was not significant. During phase 2 and 3 for the total group the additional percentage remaining caries-free was 1.5% to 26.3% which was statistically significant and for the junior group for 27 months - 1.7% to 28.3% which was nearly significant.

In brief then, the findings appear to indicate that there was a substantial reduction in caries incidence during the first 12 months following application of the stannous fluoride solution, but this reduction was somewhat less during the following 8 to 15 months even with a second application of the solution.

There is a possibility that this lessening of effectiveness may be accounted for in part by the stannous fluoride used in the study. This was obtained in 1958 prior to the start of the study and the same supply was used throughout. It was first applied in September 1959 for phase 2, more than a year after it was received, and again in September 1960, over two years later. It has since been learned that the solubility of stannous fluoride may decrease with age, resulting in reduced effectiveness.

The differences between new lesions in anterior and posterior surfaces shown in table 5, Appendix "A" is very marked. During phase 2 an average reduction of 61.0% was recorded in posterior surfaces compared to 39.2% in the anterior. In phase 3 new posterior lesions were reduced by an average of 35.6%, whereas, there was no difference in new anterior lesions.

Since posterior surfaces appeared to be most affected by the agent, a comparison of lesions occurring in specific posterior uninvolved surfaces is given in table 6, Appendix "A". These findings indicate that the percentage reduction is very high and statistically significant in proximal and occlusal surfaces but negligible and not significant in the buccal and lingual posterior surfaces. It is theorized that this could be due to the fact that adaptation of the rubber dam is more difficult on the buccal and lingual surfaces, particularly in the posterior region of the mouth.

Summary

The results of a study to determine the effectiveness of a 10% solution of stannous fluoride, applied topically to the teeth, as a means of reducing the incidence of dental caries in a military population of young adult males are presented. The most significant findings were:

- a. In the first 12 months following application of the stannous fluoride there was an average reduction in the DMFS increment of 54.0% which was statistically highly significant.
- b. During an eight-month period following a second application to the experimental sides of the junior group only, there was an average reduction in DMF surfaces of 25.7% which was not significant.
- c. The findings indicated a greater effectiveness in the posterior region of the mouth, particularly in the posterior proximal and occlusal surfaces.

Conclusion

Essentially this study must be considered a pilot study since it was the first of its kind carried out by the RCDC and because of the limited size of the study group. However, it is considered that sufficient evidence is presented to warrant further investigation with larger groups to test the principle of applying stannous fluoride solution with a rubber dam in place.

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List of Tables to Appendix "A"

- Table 1 - Evaluation of Results DMF Surfaces as the Index of Caries Experience
Table 2 - Evaluation of Results using new Lesions as Index of Caries Experience
Table 3 - Evaluation of Results using new Lesions as Index of Caries Experience
Table 4 - Proportions Remaining Caries-Free
Table 5 - Comparison new Lesions Occurring in Posterior and Anterior Uninvolved Surfaces.
Table 6 - Comparison new Lesions Occurring in Specific Posterior Uninvolved Surfaces

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TABLE 1

EVALUATION OF RESULTS DMF SURFACES AS THE INDEX OF CARRIES EXPERIENCE

PHASE	DURATION	NO OF SUBJECTS	NUMBER		AVERAGE INCREMENT		AVERAGE REDUCTION	95% CONFIDENCE INTERVAL	SIGNIFICANCE
			EXP	CONT	EXP	CONT			
2	12 Months	80	69	150	.863 (.141)	1.875 (.228)	54.0%	25.4% to 82.6%	Highly Significant
3	8 Months	79	49	66	.620 (.092)	.835 (.112)	25.7%	-8.9% to 60.5%	Not Significant
3 Jr Group	8 Months	45	31	36	.689 (.136)	.800 (.149)	13.9%	-36.6% to 64.4%	Not Significant
3 Sr Group	8 Months	34	18	30	.529 (.112)	.882 (.170)	40.0%	-6.0% to 86.1%	Not Significant
3 Jr Group	15 Months	45	57	65	1.267 (.170)	1.444 (.231)	12.3%	-27.5% to 52.0%	Not Significant
2 and 3	20 Months	79	116	212	1.468 (.181)	2.684 (.288)	45.3%	19.9% to 70.7%	Highly Significant
2 and 3 Jr Group	20 Months	45	76	134	1.689 (.284)	2.978 (.446)	43.3%	7.8% to 78.8%	Significant
2 and 3 Sr Group	20 Months	34	40	78	1.176 (.174)	2.294 (.302)	48.7%	18.3% to 79.2%	Highly Significant
2 and 3 Jr Group	27 Months	45	101	165	2.244 (.306)	3.667 (.519)	38.8%	6.0% to 71.6%	Significant

Note: Figures in parenthesis are standard errors.

TABLE 2

EVALUATION OF RESULTS USING NEW LESIONS AS INDEX OF CARIES EXPERIENCE

PHASE	DURATION	NO OF SUBJECTS	LESIONS OCCURRING IN ALL PREVIOUSLY CARIES-FREE SURFACES						SIGNIFICANCE
			AVERAGE				AVERAGE REDUCTION	95% CONFIDENCE INTERVAL	
			NUMBER		INCREMENT				
			EXP	CONT	EXP	CONT			
2	12 Months	80	85	157	1.063 (.147)	1.963 (.229)	45.8%	18.1% to 73.6%	Highly Significant
3	8 Months	79	66	87	.835 (.111)	1.101 (.155)	24.2%	-10.5% to 58.9%	Not Significant
3 Jr Group	8 Months	45	33	47	.733 (.152)	1.044 (.206)	29.8%	-19.3% to 78.8%	Not Significant
3 Sr Group	8 Months	34	33	40	.971 (.158)	1.176 (.233)	17.4%	-22.2% to 57.1%	Not Significant
3 Jr Group	15 Months	45	60	89	1.333 (.208)	1.978 (.388)	32.6%	-11.9% to 77.1%	Not Significant
2 and 3	20 Months	79	149	243	1.886 (.206)	3.076 (.338)	38.7%	12.9% to 64.4%	Highly Significant
2 and 3 Jr Group	20 Months	45	82	147	1.882 (.308)	3.267 (.528)	44.2%	11.9% to 76.6%	Significant
2 and 3 Sr Group	20 Months	34	67	96	1.971 (.248)	2.824 (.352)	38.7%	-0.3% to 60.7%	Nearly Significant
2 and 3 Jr Group	27 Months	45	108	193	2.400 (.356)	4.289 (.694)	44.0%	7.7% to 80.4%	Significant

Note: Figures in parentheses are standard error

TABLE 3

EVALUATION OF RESULTS USING NEW LESIONS AS INDEX OF CARIES EXPERIENCE

PHASE	DURATION	NO OF SUBJECTS	LESIONS OCCURRING IN PREVIOUSLY CARIES-FREE UNFILLED SURFACES						SIGNIFICANCE
			NUMBER		AVERAGE INCREMENT		AVERAGE REDUCTION	95% CONFIDENCE INTERVAL	
			EXP	CONT	EXP	CONT			
2	12 Months	80	51	120	.638 (.116)	1.500 (.190)	57.5%	27.7% to 87.2%	Highly Significant
3	8 Months	79	41	56	.519 (.084)	.709 (.103)	26.8%	-10.7% to 64.3%	Not Significant
3 Jr Group	8 Months	45	24	31	.533 (.120)	.689 (.136)	22.6%	-29.9% to 75.2%	Not Significant
3 Sr Group	8 Months	34	17	25	.500 (.146)	.735 (.157)	32.0%	-26.3% to 90.2%	Not Significant
3 Jr Group	15 Months	45	43	59	.956 (.151)	1.311 (.226)	27.1%	-14.4% to 68.6%	Not Significant
2 and 3	20 Months	79	91	173	1.152 (.151)	2.190 (.246)	47.4%	21.0% to 73.8%	Highly Significant
2 and 3 Jr Group	20 Months	45	56	107	1.244 (.231)	2.378 (.384)	47.7%	10.0% to 85.4%	Highly Significant
2 and 3 Sr Group	20 Months	34	35	66	1.029 (.169)	1.941 (.256)	47.0%	15.4% to 78.6%	Highly Significant
2 and 3 Jr Group	27 Months	45	73	137	1.622 (.256)	3.044 (.468)	46.7%	11.6% to 81.8%	Significant

Note: Figures in parentheses are standard error

TABLE 4PROPORTIONS REMAINING CARIES-FREE

PHASE	DURATION	NO OF SUBJECTS	NUMBER		PROPORTION		95% CONFIDENCE INTERVAL	SIGNIFICANCE
			EXP	CONT	EXP	CONT		
Phase 2	12 Months	80	33	17	.413	.213	5.6% to 34.4%	Significant
Phase 3	8 Months	79	38	35	.481	.443	-12.0% to 19.6%	Not Significant
Phase 2 and Phase 3	20 Months	79	21	10	.266	.127	1.5% to 26.3%	Significant
Phase 2 and Phase 3	27 Months	45	10	4	.222	.089	-1.7% to 28.3%	Nearly Significant

TABLE 5

COMPARISON NEW LESIONS OCCURRING IN POSTERIOR AND ANTERIOR

UNINVOLVED SURFACES

Phase	Dura- tion	No of Subj- ects	Side	POSTERIOR					ANTERIOR				
				Num- ber	Aver- age Incre- ment	Aver- age Reduc- tion	95% Confli- dence Inter- val	Signif- icance	Num- ber	Aver- age Incre- ment	Aver- age Reduc- tion	95% Confli- dence Inter- val	Signif- icance
2	12 Months	80	Exp Cont	37 95	.463 (.097) 1.188 (.154)	61.0%	30.4% to 91.7%	Highly Signif- icant	14 23	.175 (.052) .288 (.075)	39.2%	-24.0% to 102.4%	Not Signif- icant
3	8 Months	79	Exp Cont	29 45	.367 (.072) .758 (.085)	35.6%	-3.3% to 74.6%	Nearly Signif- icant	12 12	.150 .150	-	-	Not Signif- icant
2 and 3	20 Months	79	Exp Cont	66 138	.835 (.125) 1.747 (.193)	52.2%	25.9% to 78.5%	Highly Signif- icant	25 35	.316 (.073) .443 (.096)	28.7%	-25.5% to 82.8%	Not Signif- icant
2 and 3	27 Months	45	Exp Cont	54 107	1.200 (.205) 2.378 (.355)	49.5%	15.1% to 84.0%	Signif- icant	18 28	.400 (.111) .622 (.179)	35.7%	-32.2% to 103.5%	Not Signif- icant

Note: Figures in parentheses are standard errors.

TABLE 6
COMPARISON NEW LESIONS OCCURRING IN SPECIFIC POSTERIOR UNINVOLVED SURFACES

Phase	Duration	No. of Subjects	Side	PROXIMAL SURFACES					OCCLUSAL SURFACES					BUCCAL & LINGUAL SURFACES				
				New Lesions	Average Increase	Average Reduction	95% Confidence Interval	Significance	New Lesions	Average Increase	Average Reduction	95% Confidence Interval	Significance	New Lesions	Average Increase	Average Reduction	95% Confidence Interval	Significance
2	12 Months	80	Exp Cont	10 39	(.125) (.488) (.092)	74.4%	31.8% to 117.0%	Highly Significant	5 25	(.063) (.027) (.070)	79.9%	31.9% to 127.8%	Highly Significant	22 32	(.275) (.066) (.400) (.080)	31.3%	-20.8% to 83.3%	Not Significant
3	8 Months	79	Exp Cont	4 17	(.051) (.025) (.053)	76.3%	28.0% to 131.2%	Significant	4 12	(.051) (.025) (.051)	66.4%	-0.9% to 141.5%	Nearly Significant	21 15	(.265) (.064) (.194) (.051)	-39.5%	-125.8% to 46.8%	Not Significant
2 and 3	20 Months	79	Exp Cont	14 53	(.177) (.053) (.067) (.106)	73.6%	38.5% to 108.8%	Highly Significant	9 37	(.114) (.036) (.481) (.073)	76.3%	42.6% to 110.0%	Highly Significant	43 47	(.544) (.091) (.608) (.099)	10.5%	-33.9% to 54.9%	Not Significant
2 and 3	27 Months	45	Exp Cont	13 42	(.289) (.092) (.393) (.164)	69.0%	28.7% to 109.3%	Highly Significant	11 33	(.244) (.064) (.733) (.135)	66.7%	26.1% to 107.4%	Highly Significant	30 33	(.667) (.144) (.733) (.168)	9.0%	-51.3% to 69.3%	Not Significant

Note: Figures in parentheses are standard errors.

NEW MEMBERS OF THE CORPS

Congratulations and a hearty welcome are extended to twelve new Dental Officers. It is hoped that they will all enjoy their new service environment and that this will be the beginning of a long and rewarding career in the RCDC.

Capt	NH	Andrews	Dalhousie	HQ Manitoba Area, Winnipeg
Capt	LTFB	Archambault	Montreal	HMCS Cornwallis
Capt	PAA	Dailyde	Toronto	Griesbach Bks, Edmonton
Capt	WJ	Froese	Manitoba	HQ Manitoba Area, Winnipeg
Capt	TM	Johnston	Toronto	HQ Manitoba Area, Winnipeg
Capt	GA	Johnson	Toronto	Whitehorse
Capt	VD	Kvedaras	Toronto	RCAF Stn Trenton
Capt	JPA	Legendre	Montreal	Currie Bks, Calgary
Capt	NA	McFarlane	Toronto	HMCS Cornwallis
Capt	AB	Perkin	Toronto	CFH Kingston
Capt	WE	Russell	Dalhousie	Gagetown
Capt	WJ	Sinclair	Toronto	RCAF Stn Downsview

An equally warm welcome is extended to the following personnel who have been recently transferred to the RCDC.

Cpl	RW	McDonald	-	No 1 Dent Eqpt Dep
Cpl	JRR	Roy	-	Longue Pointe
Cpl	B	Vandervaat	-	DGDS
Pte	G	Clark (RCASC)	-	4 Fd Dent Coy
Pte	DJ	Davies	-	Halifax
Pte	GN	Fathers	-	RCDC School
Pte	RJ	Forward	-	Uplands
Pte	JRY	Gratton	-	RCDC School
Pte	TJ	Herrett	-	Edmonton
Pte	C	Lachance	-	Valcartier
Pte	DK	Mand	-	Churchill
Pte	RA	Neill	-	Edmonton
Pte	LG	Peverill	-	RCDC School
Pte	OR	Sorensen	-	Pictou
Pte	PD	Whynott	-	No 1 Dent Eqpt Dep
AW2	I	Gruener	-	St Jean
Mrs	AJ	Stewart (Pt V)	-	RCAF Avenue Rd, Toronto

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PROMOTIONS

The following members of the Corps and RCAF Airwomen have been promoted since the last issue of the Quarterly was published and to them we extend our heartiest congratulations:

Sgt	DJ	Pierce (RCAF)	-	to F/Sgt
Sgt	TW	Sullivan	-	to Ssgt
Sgt	CMB	Torrens (RCAF)	-	to F/Sgt
Cpl	J	Dion	-	to Sgt
Cpl	WR	Dowell	-	to Sgt
Cpl	P	Fox	-	to Sgt
Cpl	FJ	Reid	-	to Sgt
Cpl	EPH	Sprathoff	-	to Sgt
Cpl	HD	Wagstaff	-	to Sgt

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RETIREMENTS AND RELEASES

Best wishes for a happy future are extended to the following WOs and NCOs who have retired from the Corps on reaching their age limit.

WO 2	PJ	Mulholland	-	HQ No 13 Dent Coy, RCAF Stn Trenton
Ssgt	WB	Weir	-	HQ No 13 Dent Coy, RCAF Stn Trenton
Sgt	MH	Redmond	-	HMCS Shearwater

In addition, many RCDC or attached personnel have taken their release during the past three months. We thank them for their contribution to the overall health services of our Canadian Forces.

Lt Col	LC	Cameron
Capt	JO	Bowman
Capt	HF	MacKay
Sgt	JA	Brennan (RCAF)
LAW	YML	Boulianne
AW1	BL	Carroll
LAW	MIE	Cornut
Mrs	BL	Darling (Pt V)
Pte	TC	Doucet (CWAC)
AW1	FW	English
Pte	RL	Geddes
AW1	E	Graham
AW1	FR	Hawryluk
Mrs	J	Lecompte (Pt V)
AW1	CMR	Lutz
AW1	M	Poulson
LAW	ML	Solomon
AW1	LJP	Travena
AW1	HI	Walko

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POSTINGS

Most of the summer postings have been effected during the period of this Quarterly and some will occur long before the next issue is published. Listed hereunder are the location changes of our posted personnel.

Lt Col	WW	Anglin	-	to RCAF Stn St Jean from Camp Petawawa
Lt Col	RE	Brown	-	to The RCDC School from HMCS Naden
Lt Col	SG	Bagnall	-	to DGDS from The RCDC School
Lt Col	G	MacDougall	-	to HMCS Naden from The RCDC School
Major	JC	Brick	-	to RCAF Stn Uplands from DGDS
Major	RJ	Bryant	-	to RCAF Stn Winnipeg from RCAF Stn Portage la Prairie
Major	JVP	Chatwin	-	4 Fd Dent Coy from CFH Kingston
Major	JL	Craig	-	to AFHQ Cl Ottawa from The RCDC School
Major	WK	Dickie	-	to CFH Kingston from HQ NWHS Whitehorse
Major	PE	Fafard	-	to Ft Churchill from RCAF Stn Centralia
Major	EMC	Franklin	-	to RCAF Stn Centralia from 35 Fd Dent Unit
Major	JW	Jolly	-	to Currie Bks Calgary from Fort Churchill
Major	AL	Kelland	-	to CBUME from HQ Cencom Oakville
Major	HR	Kettyls	-	to DGDS from HQ Calgary Garrison
Major	SW	Muller	-	to HQ NWHS Whitehorse from RCAF Stn Winnipeg

POSTINGS cont'd

Major	DH	Protheroe	- to The RCDC School from DGDS
Major	DH	Skinner	- to Camp Petawawa from 4 Fd Dent Coy
Major	PS	Sills	- to The RCDC School from RCAF Stn Uplands
Major	EJC	Small	- to HQ Cencom Oakville from CBUME
Major	IW	Susser	- to 35 Fd Dent Unit from RCAF Stn Greenwood
Capt	RD	Bunt	- to RCAF Stn Trenton from CBUME
Capt	MDG	Conrad	- to CBUME from RCAF Stn Greenwood
Capt	PJJ	Coulombe	- to RCAF Stn Clinton from 4 Fd Dent Coy
Capt	RH	Headley	- to 1 QOR of C, Ft McLeod to 8 CH, Ft Beausejour
Capt	JGB	Parent	- to RCAF Stn Goose Bay from RCAF Stn St Jean
Capt	WF	Shaw	- to 4 Fd Dent Coy from Camp Gagetown
Capt	OA	Tucker	- to RCAF Stn Portage la Prairie to RCAF Stn Winnipeg
WO2	EM	Lobb	- to The RCDC School from HQ Quecom
WO2	RG	Peebles	- to RCAF Stn Trenton from HQ Edmonton
WO2	AG	Ponton	- to The RCDC School from QM Stores Calgary
Ssgt	RD	McHugh	- to HQ Edmonton from DGDS
Ssgt	L	Lawson	- to QM Stores St Jean from 35 Fd Dent Unit
Ssgt	JR	Savoie	- to 35 Fd Dent Unit from The RCDC School
Sgt	JP	Carrier	- to DGDS from HQ Montreal
Sgt	DD	Casson	- to 11 Dent Coy from RCAF Stn Moose Jaw
Sgt	JE	Clarke	- to HMCS Cornwallis from 4 Fd Dent Coy
Sgt	J	Dion	- to CBUME from HQ Edmonton
Sgt	HK	Drawe	- to HQ Calgary Gar from CBUME
Sgt	WB	Gilbert	- to HQ BC Area Vancouver from RCAF Stn Trenton
Sgt	DM	Hamilton	- to RCAF Stn Winnipeg from Fort Osborne Barracks Winnipeg
Sgt	MA	James	- to DGDS from HQ Eascom Halifax
Sgt	CC	Jewson	- to Camp Gagetown from 7 PD London
Sgt	ES	Knoll	- to RCAF Stn Chatham, NB from The RCDC School
Sgt	DJ	Pierce (RCAF)	- to RCAF Stn Greenwood from RCAF Stn Goose Bay
Sgt	KS	Rothwell	- to HQ Calgary Gar to 35 Fd Dent Unit
Sgt	JH	Sadler	- to RCAF Stn Rockcliffe from The RCDC School
Sgt	AF	Semple	- to No 1 Dent Eqpt Dep Petawawa from The RCDC School
Sgt	RK	Shappee	- to RCSME Vedder Crossing from RMC Kingston
Sgt	KLM	Wallace	- to 7 PD London from Camp Gagetown
Sgt	GW	Wilkinson	- to 4 Fd Dent Coy from HQ BC Area Vancouver
Cpl	RG	Brighty	- to 12 Dent Coy from CJATC Rivers, Man
Cpl	JWW	Broomfield	- to RCAF Stn Trenton from RCAF Stn Cold Lake
Cpl	JF	Kennedy	- to The RCDC School from RCAF Stn Trenton

POSTINGS cont'd

Cpl	JG	MacDonald	- to HMCS Cornwallis from Ft Churchill
Cpl	GAMC	Ridley (RCAF)	- to RCAF Stn Rockcliffe from 35 Fd Dent Unit
Cpl	JARG	Rochon	- to No 1 Dent Eqpt Dep from QM Stores St Jean
Cpl	A	Schuh	- to Griesbach Bks Edmonton from HMCS Naden
Pte	TJ	Deloughery	- to HQ Camp Petawawa from The RCDC School
AW2	CM	Fraser	- to 6 RD Trenton from RCAF Stn St Jean
Pte	WD	Horne	- to The RCDC School from C Pro C School Camp Borden
Mrs	FB	Jankowski (Pt V Dental Nurse)	- to RCAF Stn Hubert from RCAF Stn Winnipeg
Pte	RB	Johnson	- to RCAF Stn Penhold from The RCDC School
Pte	DL	Kerr	- to CJATC Rivers from HQ Camp Shilo
AW1	ME	Koch	- to RCAF Stn Clinton from RCAF Stn St Jean
Pte	JM	McLean	- to Ft Churchill from Camp Gagetown
Pte	RG	Moffatt	- to HMC Dockyard from Gds Depot Petawawa
AW2	JM	Roberts	- to RCAF Stn Bagotville from RCAF Stn St Jean

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TRAINING

Corps personnel have attended the following courses recently:

US Naval Dental School - Complete Denture Course - 21-25 May 62

Lt Col	CM	Cornish
Lt Col	RHG	Cunningham

Tri-Service Medical and Dental Officers NBCW Course, Camp Borden - 9-22 Jun 62

Major	TD	Cobb
Capt	GR	Myles

Projected Visual Aid (Technifax Eqpt) Course, RCASC School Camp Borden - 8-11 May 62

Capt	CA	Casterton
WO2	EM	Lobb

First Aid Instructor Tri-Service Course - CFMSTC, Camp Borden 9-27 Apr 62

WO2	EK	Abernethy
WO2	H	Thorsson

Clk Adm Cp 1 Course - RCASC School, Camp Borden, 5 Apr - 29 Jun 62

Cpl	RS	Walker
Cpl	NAJ	Eady

★ ★ ★ ★ ★ ★ ★ ★ ★ ★

VITAL STATISTICS

NO 1 DENT EQPT DEP

Marriage

Cpl Paul Dumas was married to Miss Cecilia H Brazeau at Pembroke, Ont,
23 Jun 62.

NO 11 DENT COY

Births

A son, Alexander Scott, was born to Maj and Mrs IAC MacDonald on 7 Jun.

Capt and Mrs P Morin have a new daughter, Kelly Diane, born 15 May.

On the 26th of Apr, a son Peter Donald was born to Sgt and Mrs DR Piche.

NO 12 DENT COY

Births

To Sgt and Mrs DT Murley, a daughter, Heather Isobel.

Hospital

Capt MAJ LaChapelle - 2 May -
Sgt AL McIsaac - 14 May - 7 Jun

NO 13 DENT COY

Hospital

Sgt MP Foley (RCAF) 4-23 Jun
Cpl WL Wylie - 5 Jul -
Pte JR Powell - 7-28 May

NO 14 DENT COY

Hospital

Cpl WE Bussell was admitted to Deer Lodge Hospital for surgery on
4 Jun 62.

NO 15 DENT COY

Births

A daughter, Marie Louise, born to Sgt and Mrs JA DeBlois on 11 May.

Marriages

LAW LA Wiens was married to Mr Martin Van der Stap on 15 May at Goose
Bay, Lab.

Hospital

Sgt TH Southin - 16 May - 1 Jun
Cpl JR Pouliot - 20 Jun -

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DIRECTORATE OF DENTAL SERVICES NEWS

DGDS Attends CDA Meeting

Brig KM Baird recently attended the Board of Governors' Meeting of the CDA held in Vancouver BC. Following this, he attended the CDA Meeting and met with Service officers from 11 Dent Coy RCDC. Pictured below is Brig Baird with Col JF Edgecombe, Honorary Colonel Commandant of the RCDC and currently New Brunswick Member of the Board of Governors.



Duty Trips and Visits

The annual inspection for the Militia General Efficiency Competition was conducted this year by Col IAL Millar. It is anticipated that the announcement of the awards for the current year will be made in the very near future.

Col and Mrs GB Shillington will return to Canada from Europe early in August. While abroad, Col Shillington inspected the personnel and facilities of No 4 Fd Dent Coy and 35 Fd Dent Unit and represented the DGDS at the annual meeting of the Federation Dentaire Internationale in Cologne, Germany. His itinerary also included a visit to London to confer with the heads of the Dental Services of the Royal Navy, British Army and Royal Air Force.

Directorate Well Represented on AHQ Rifle Team

The appointment of Maj JC Brick as Captain of the AHQ Rifle Team, was announced recently. This honour highlights several years of active participation on the team, which this year included another member of the Directorate staff, Cpl ADT Gardner.

DGDS Receives Award from Order of St John of Jerusalem

Brig Baird has been awarded a parchment denoting a Priory Vote of Thanks by the Order of St John of Jerusalem in 1962 in recognition of the Corps having overy ninety per cent of all ranks qualified in the Fundamentals of First Aid or higher qualification.

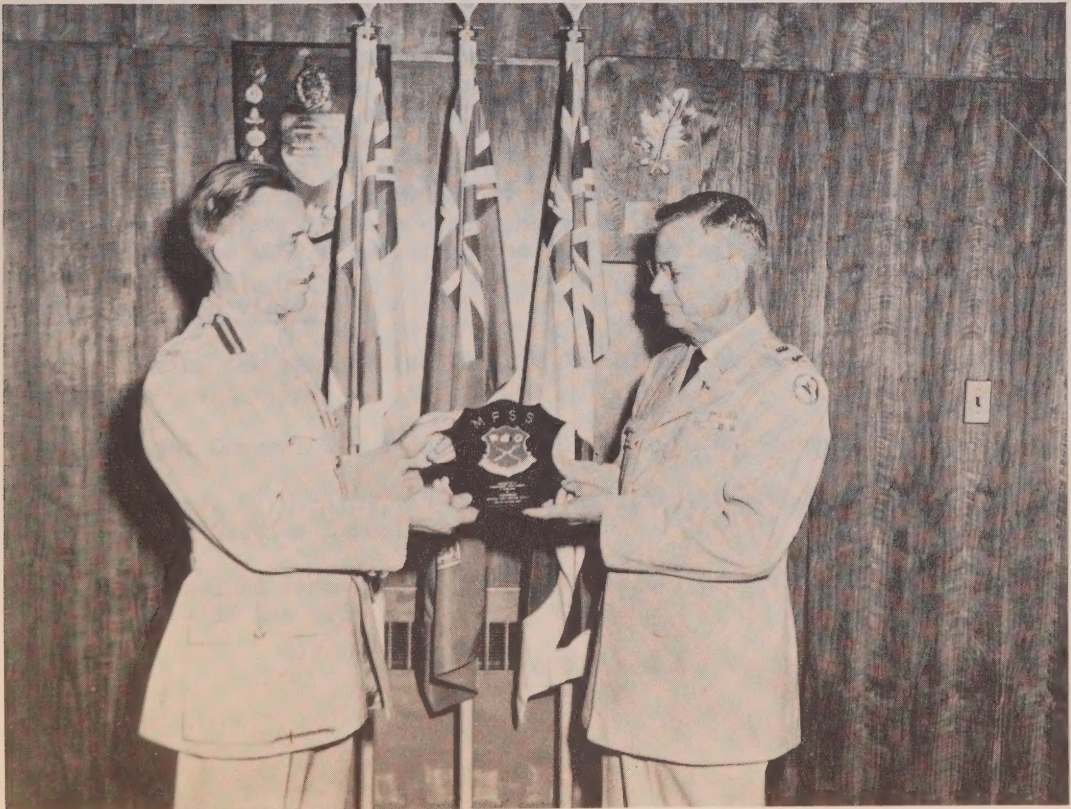
★ ★ ★ ★ ★ ★ ★ ★ ★ ★

THE RCDC SCHOOL NEWSLt Col JW Turner Presents Lecture

Lt Col Jay Turner, currently on staff of the US Naval Dental School at Bethesda, Md as an exchange instructor, presented a paper entitled "Reinforced Amalgams" before members of the York County (Pa.) Dental Society at their meeting in May 62.

US Army Dental Officer Visits School

Colonel Clare T. Budge, Director of the Department of Dental Science at the Medical Field Service School of the US Army visited The RCDC School in June. An officer with a very distinguished professional and military career, Colonel Budge is a nationally-recognized oral surgeon and has held key assignments in this specialty throughout the USA. During his visit he presented a replica of the MFSS plaque to the Commandant, Colonel CE Purdy. (see photo below)



DT C1 Graduates Entertain School Staff

Graduates of the recent DT C1 Group 3 Course, namely, Miss IJ Coulter, Miss EC Whebell and Sgts AS Field, VR Kidd, SE Robertson and JH Sadler entertained the staff of the School at an informal party held at the CFMSTC Sgts' Mess Camp Borden.

Farewell Parties

The three departing officers of the School, Lt Col SG Bagnall, Lt Col G MacDougall and Major JL Craig were presented with silver mugs at appropriate farewell ceremonies in their honour at the CFMSTC Officers' Mess.

The same officers, as well as Sgts Semple, Knoll and Sadler were similarly feted at the Camp Borden Curling Club by members of the staff of the School.

Present Clinic at ODA Convention

Colonel CE Purdy, Commandant, Commander RR Troxell, USN DC, Chief Instructor and Major JM Smith presented a clinic at the Annual Convention of the Ontario Dental Association held in Toronto 13 to 16 May 62. The subject of their presentation which created a great deal of interest was "Your New Dental Assistant - Effective Office Training in One Week".

Summer Training

It is interesting to note that on 9 Jul 62 there were forty subsidized dental undergraduates and three new graduates undergoing training at the School. In addition approximately twenty-five DOSP candidates were receiving First Phase training at the RCS of I. Members of the Corps will, no doubt, eagerly anticipate the additional dental service which can be provided when these candidates come to full-time service.

Three groups of introductory phase ROTP Cadets from Canservcols, numbering approximately sixty in each group, have visited the School recently. In addition, the First Phase DOSP Cadets from the RCS of I visited on 26 Jun 62.

Duty Trips and Visits

During the past few months the School has had a number of distinguished visitors:

Major General WAB Anderson, OBE, CD, Adjutant-General, AHQ - 21 Jun 62.

Colonel GJ Collins, US Army MC, Assistant Commandant of the Medical Field Service School - 4-8 Jun 62.

Colonel RA Keane, DSO, OBE, CD, Director General of Military Training, AHQ - 17 May 62.

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NO 1 DENT EQPT DEP NEWSSports

This unit held its annual fishing derby on 8 Jun 62. After many stories of the ones that got away Ssgt Sullivan came up with the largest fish to win the derby.

The Depot has been active in after-duty ball games but have yet to come up with a winning combination.

WO1 Bergland is the only golfer in this unit who has won any prizes so far this year. He will not disclose whether the prizes were low gross, low net or just consolation prizes.

Social

No 1 Dental Equipment Depot combined with No 3 Clinic and held their frolicking spring party on 15 Jun.

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11 DENT COY NEWSDGDS Visit

Brigadier KM Baird paid a welcome visit to the unit following the recent CDA Convention in Vancouver.

Hospitalization

Colonel BP Kearney had been covering the usual number of clinic inspections when his itinerary was interrupted by a short session (not serious) in hospital.

Speaking of hospitals, we seem to have been plagued by an abnormal amount of sickness during the past few months. Unfortunately the numbers involved preclude giving each casualty a line of "credit" else this issue of the Quarterly would qualify as a Who's Who in Hospital. Suffice it to say that no serious illness has been reported and all are recovering.

Summer Changes

The usual summer problems resulting from postings, leaves and training have necessitated an extra effort on the part of most clinics to maintain the traditional high standard of service with a smile. The postings listed elsewhere will attest to our qualifications in the hail and farewell department. The regrets we have felt while bidding farewell to old friends on departure have been adequately offset by the pleasure of welcoming their replacements.

No 4 Clinic, Currie Barracks Present Demonstration

The personnel of No 4 Clinic gave a demonstration on the "Role of the Dental Assistant" to members of No 59 Dental Unit RDC(M). Three bays were set up:

Surgical	- demonstrated by Mrs Sisson
Operative	- demonstrated by Mrs Phillips
Prosthetic	- demonstrated by Sgt Piche

The duties of the assistant in the Orderly Room were presented by Sgt Piche while Sgt McFadden demonstrated the laboratory tasks undertaken by dental assistants. Captains Garden and Petryk discussed dental treatment in general.

Coy Officers Attend CDA Meeting

Several officers of this unit availed themselves of the opportunity to attend the Annual Convention of the Canadian Dental Association held at Vancouver early in June.



Pictured from left to right are: Capt LC Gray, Maj MP Quinn, Col BP Kearney, Lt Col RE Brown and Maj WH Carter standing in front of the RCDC Exhibit.

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12 DENT COY NEWS

Accommodation

No 12 Coy QM Stores has moved from its present location on the third deck of the Adm Bldg, HMCS Stadacona to a section of the main deck of the same building formerly occupied by the Naval Clothing Stores. Equipment repair facilities and new quarters for HQ 12 Coy are now being provided for in this section.

Sports

Our Camp Gagetown athletes finished off the winter season in a blaze of glory. Capt By Johnston (Skip), Sgt Roy Matheson, Capt Bill Shaw and Pte Pete Peterson won the consolation event in the Eastern Command Curling Championships. Sgt Roy Matheson was a member of the Camp Gagetown and Eastern Command hockey champions.

Sgt Frank Martell led his team to the Station championship and was co-Captain on the mixed bowling championship team.

Our neophyte curlers at Cornwallis led by Sgt Harold Kirby gained the semi-final round in the Station play-offs.

Capt Jack Quackenbush is spending his time these days directing the Garrison Little League. He says it takes up more time than curling (we agree).

Social

Sgt Mike Redmond was well wined and dined on his retirement. Celebrations were held on his behalf by the personnel in the Halifax area and his former shipmates on the Bonaventure and Magnificent. Mike is going to take up residence in Hamilton, Ont and we wish him the best of luck. (see photo below)

Sgt Art James was suitably launched on his posting to DGDS. The Port Perry pundit will be greatly missed in these parts.



Pictured left to right: Sgt M Redmond, Colonel AT Roger, Capt H Bunston

New Dental Officers Win Awards

Capt WE Russell was awarded four prizes from Dalhousie University on graduation. These were the Dr John W Dobson prize, the Frank W Woodbury award for thesis, the highest standing prize and the CV Mosby book award.

Capt NH Andrews won the Frank W Woodbury award for the highest in clinical practice.

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13 DENT COY NEWS

13 Coy Officers Present RCDC Exhibit at ODA Meeting

Col AC Leman attended the Ontario Dental Association Convention 13-16 May, Royal York Hotel, Toronto along with the following officers of this unit who assisted in the presentation of the RCDC Exhibit: Lt Col RHG Cunningham, Lt Col GE Windsor, Majors PE Fafard, JVP Chatwin and PL Falkner.

Kingston Activities

Capt AB Perkin of 7 Clinic, CFH Kingston resplendent in No 1 Dress, represented the RCDC at a parade for H.R.H. The Princess Royal at the RCS of S in Kingston.

Major JVP Chatwin and WO2 JM Sherry of 7 Clinic, CFH Kingston set up a First Aid display in the Memorial Centre, Kingston for the inspection of the District Girl Guides by H.R.H. Princess Royal on 20 Jun 62.

Capt JLY Cyrenne of 4 Clinic RMC was invited to join a Board assembled at RMC 20-21 Jun 62 for the purpose of testing candidates in French Language proficiency.

Sgt HM McCurdie and Pte DH McKay are participating in Soccer this season with No 1 Sigs Unit, Kingston and RCAF Station Trenton respectively.

Part V Dental Nurse Obtains Qualification

Congratulations are extended to Miss K Heenan of 21 Clinic, London on her successful completion of the Ontario Dental Assistants' Certification course sponsored by the London Dental Society under the auspices of the Faculty of Dentistry, University of Toronto. The course was conducted in the evenings over the period Oct 61 - Apr 62 at a cost of \$75.00 to each candidate.

Social

The Sgts' Mess Trenton held a farewell party on Saturday evening 28 Jul 62 for their departing members at which WO2 PJ "Pat" Mulholland was honoured on his imminent retirement and presented with a suitably engraved silver tray by the PMC. No 13 Coy personnel in Trenton held a farewell party for Pat after work at HQ recently and presented him with a brief-case in which to carry all his papers to his future residence in California. At the same time Cpl JF "Ken" Kennedy was wished the best of luck on his move to the RCDC School and was presented with a suitable going-away gift.

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14 DENT COY NEWSCapt WJ Froese Awarded Prize

Capt WJ Froese, one of our new officers and a recent graduate of the Faculty of Dentistry, University of Manitoba, was awarded the Portnoy Prize for greatest competence in Gold Foil Restorations in Fourth Year Dentistry.

Duty Trips and Visits

Lt HF Doyle visited RCAF Stn Beausejour, Man to complete handover of dental equipment from RCAF to RCDC on 19 Jun 62. Beausejour is now officially one of our part-time clinics.

Social

Lt Col MJ Snidal, CO 57 Militia Dental Unit, extended an invitation to personnel of this unit to attend the Annual All Ranks Party on 5 May 62. This successful affair was attended by Lt Col and Mrs RB Jackson, Major and Mrs LA Richardson, Lt and Mrs HF Doyle and WO1 and Mrs AM Careau.

The annual posting party was held on 22 Jun at RCAF Stn Winnipeg. This event affords all RCDC members and associated personnel in the Garrison an opportunity to welcome new arrivals to 14 Coy and to bid farewell to those being posted out.

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15 DENT COY NEWSSummer Concentration

Capt JPP Prud'homme and Pte JAY Ferland proceeded to Camp Gagetown for the summer concentration from 6 Jun - 31 Jul 62.

Bereavement

Our sincere sympathies are extended to Capt and Mrs LJ Bosse whose infant daughter Marie died shortly after she was born on 27 Jun 62.

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4 FD DENT COY NEWSUnit Undertakes Field Training

With the exception of two sub-sections, the entire unit moved into bivouac at Sennelager, Germany from 16 Jun to 7 Jul. In addition to normal dental duties, all personnel completed gas and grenade training and reclassified on personal weapons where applicable.

Officers Attend Dental Conference

Lt Col Evans, Maj Skinner, Capt Crossman and Capt Kelly attended the annual USAFE-USAREUR dental conference at Carmish, Bavaria 19-20 May 62.

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CBUME NEWSAccommodation - Recreational

A patio 14' x 18' x 3' complete with cobbled floor and built-in Bar-B-Q, has been added to one end of the dental quarters. This addition has been most welcome for week-end social gatherings. Furthermore, our date and pomegranate trees should be ready to produce their fruits by August. We are taking export orders now!

Medals Parade

On 7 Jun the Canadian Dental Detachment held a "Medals" parade which was commanded by Major Kelland. Canadian Forces Decorations (CD) were presented at that time to Sgts Storms and Strub by the Camp Commander Col Rochester. Ssgt Schell and Sgt Dancer have also received their "Sand Dune" Medal since the last Quarterly was published.

Social Events

The CBC variety show entertained the troops at Camp Rafah between 12-24 May. They were well received and appreciated by all who saw their performances.

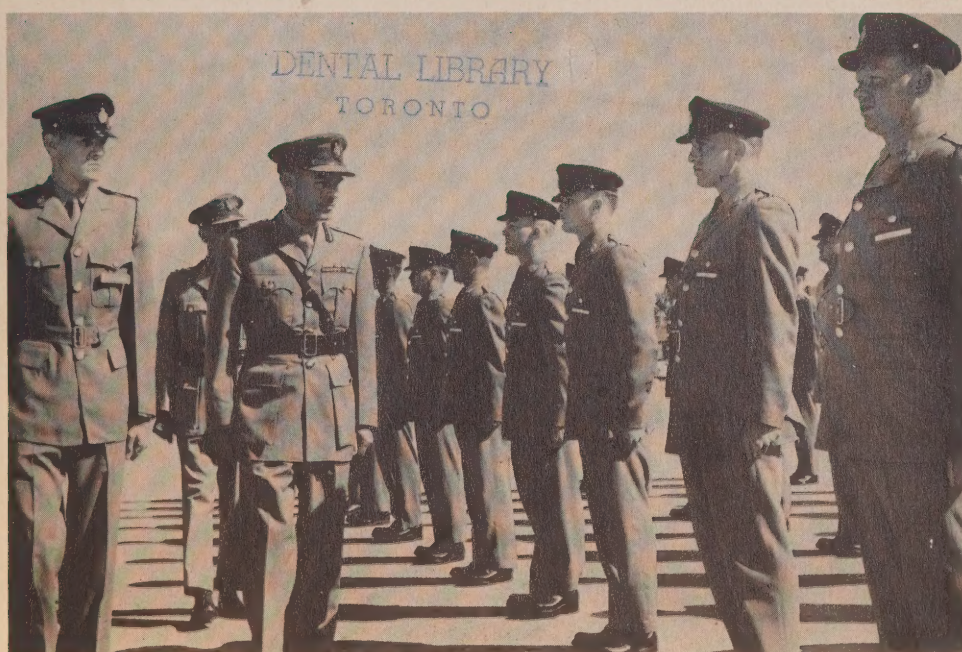
On 24 May a "Canada Day" beach party was held for the whole of Camp Rafah. Features of the party were; camel races, donkey polo, and hand ball competitions by various units. Free Canadian beer was on distribution and the food consisted of hot dogs and hamburgers. It was a tiring but most pleasant celebration for all personnel at the Camp.

A "Going-Away" party was held on 9 Jun 62 in honour of Major EJC Small and Sgt HK Drawe. Refreshments were served and both Major Small and Sgt Drawe received a suitably engraved brass dinner gong as a memento of their tour with the Detachment.

Ssgt Schell and Sgt Storms joined the "fighting troops" (RCDs) in June for a one-day tour of the International Frontier. They report that there is nothing out there but sand, sand and more sand.

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The
**ROYAL CANADIAN
DENTAL CORPS**
Quarterly



VOLUME 3 NUMBER 3

OCTOBER 1962

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THE RCDC QUARTERLY

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Lt Col GR Covey
Lt Col DH Hillier

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E D I T O R I A L

The Royal Canadian Dental Corps salutes its sister organization, the United States Naval Dental Corps on the occasion of its fifteenth anniversary celebrated on the 22nd of August of this year. While this date preceded by only a few years that of the founding of the Canadian Army Dental Corps, as it was then known, the vast difference in population of the two countries has permitted, and indeed made necessary, a much larger and more complex body to attend to the dental requirements of the US Navy.

This vast organization might well have ignored its smaller sister to the north but such, indeed, has not been the case and willing assistance has been offered in a variety of methods. These include the provision of courses of varying duration as part of the education of future instructors at The RCDC School; short refresher courses for clinically employed officers; assistance in the inauguration of new courses by the provision of instructors; and, lately, the enrolment of officers in the extension education program conducted by the US Naval Dental School.

Royal Canadian Dental Corps officers have been privileged to enjoy the association of US Naval Dental Corps officers attending clinical courses at The RCDC School while the officer exchange program between the respective Schools is now in its second year and, it is believed, to the mutual benefit of both organizations.

The RCDC extends best wishes to the USNDC for future success and prosperity and looks forward with confidence to a continuation of the cordial relationship that has developed over the years between the two Corps.

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SUMMER TRAINING - SUBSIDIZED DENTAL UNDERGRADUATES

Major DH Protheroe, DFC, CD, DDS, MPH

During the months of July and August for the past fourteen years, the staff of The RCDC School has been engaged in preparing subsidized dental undergraduates for service as dental officers in the Corps. The importance of this activity is evident when it is considered that more than 75 percent of the present dental officers entered the Corps via the subsidization route. Many of these officers look back on the summers they spent as members of the Regular Officers' Training Plan, 21-Month Subsidization Plan or Canadian Officers' Training Corps as among the highlights of their service careers. The 1962 summer training programme, which marked the first time that candidates in the new Dental Officers' Subsidization Plan had participated, has only recently been completed and the time seems opportune to outline the summer training given subsidized dental undergraduates.

The military training programme for dental undergraduates enrolled in the Dental Officers' Subsidization Plan is undertaken in three phases, each of which contains a theoretical portion, taken during the academic year, and a practical portion, taken during the summer.

FIRST PRACTICAL PHASE

The first practical phase is conducted at The Royal Canadian School of Infantry, Camp Borden. Candidates receive junior officer training and instruction in the basic skills of the Army. Subjects included in the syllabus are: weapons, fieldcraft, field engineering, first aid, hygiene and sanitation, leadership, man-management, map using, military law, NBCW, physical training, signal communications, staff duties in the field, military writing and tactics. Although this appears to be a tough schedule, much of the training is conducted out of doors to develop physical fitness and plenty of time is left for recreation.

Students who have undergone this training are undoubtedly the best qualified to describe it. The following is a description of first phase activities by four third phase cadets from the University of Toronto: (1) "The summer is filled with a harmonious blend of basic training, recreation and social activities. Basic training, although at times physically fatiguing, leaves the cadet with a host of memorable experiences and numerous new friendships. Considerable time is devoted to basic drill during which the cadet progresses from the simple movements he learned in the first theoretical phase to the more complicated ones of the practical phase. A thorough and interesting course on weapons is given which includes the C1 and C2 rifles, sub-machine carbine, pistol, rocket launcher and hand grenades. The cadets first learn the theory and safety features of these weapons before they are allowed to fire them under careful supervision. Perhaps the most interesting aspect of the summer is the fieldcraft training. Here the cadets become familiar with living in the field. Throughout basic training each cadet assumes various commands and learns to accept responsibility and show his leadership qualities. Recreational facilities are abundant at Camp Borden. Forty minutes a day are set aside for physical training which includes calisthenics and track and field for those interested. There are also facilities for tennis, golf, billiards, ping pong, baseball and swimming. Social facilities are never wasted on the cadet at the Infantry School and the highlight of the summer social life is the Cadet Ball. The colour and pageantry associated with this affair is sufficient to make any cadet proud to be a member of the Armed Forces and in particular the Dental Corps."

This year, for the first time, all of the RCDC cadets attained marksman or 1st class shot with the FN CL rifle and considering that many had never fired a rifle before, this was a record of which they were justly proud.

The photographs below depict the type of training that the first phase cadets receive. It is evident that they are fit and morale is high.



Onlooker: O/Cdt EF Foley, (Dalhousie)
Map User: O/Cdt JO Strom, (Alberta)
Compass: O/Cdt GDV Dippel, (McGill)

Firer: O/Cdt GHJC Nadeau, (Montreal)
AI: WO2 Brown, Cdn Gds
Left: O/Cdt JAA Boucher, (Montreal)
Right: O/Cdt BB Berezan, (Alberta)

SECOND PRACTICAL PHASE

In line with the tri-service role of the RCDC, the second practical phase training is intended to provide cadets with a basic knowledge of the RCN and RCAF as well as special to Corps aspects of the RCDC. The training is conducted in three stages: Stage 1 with the RCN at HMCS Cornwallis, N.S. and HMCS Stadacona, Halifax; Stage 2 with the RCAF at RCAF Station Centralia, Ont; and Stage 3 at The RCDC School, Camp Borden.

This year Stage 1 began on 1 Jun at the Leadership School, HMCS Cornwallis. Lectures were given in RCN administration, history, customs, dress, law, training, ships and the role of the RCN. Social life included a mess dinner on 11 Jun and on 13 Jun Lt Col NA Butcher, with the help of the officers of his clinic, arranged a lobster and beer party as a finale to a day of boatwork and recreation at the RCN beach at Raven Haven. As a parting gesture to Cornwallis, the cadets "kindly" coloured the officers' swimming pool a delicate shade of pink and launched a 23-foot whaler into it.

On 17 Jun the cadets arrived at Stadacona for a one-week visit. During this period they were given a first-hand look at the naval installations and ships as well as a few lectures. Some of the highlights were: a day at sea aboard HMCS Mallard and HMCS Cormorant; a visit to HMCS Shearwater at Dartmouth for a fly past and rescue drill demonstration; and a tour to Peggy's Cove, a typical east coast fishing village.

The second stage of Phase 2 commenced on 24 Jun at RCAF Station Centralia following a flight from HMCS Shearwater in an RCAF North Star aircraft. An orientation course was given by the RCAF similar to that provided by the RCN at HMCS Cornwallis. In addition, there were recreational afternoons and a tour to Grand Bend, a trip to Stratford to see a

production of "Taming of the Shrew" at the Shakespearian theatre, as well as an industrial tour of Labatt's Brewery in London.

The third stage which is conducted at The RCDC School commenced on 7 Jul for a five-week period. The purpose of the course at The RCDC School is to provide a basic knowledge of the Corps. The subjects covered are: organization and administration of the RCDC; documentation and treatment policy; medico-legal responsibilities; equipment maintenance; clinical and laboratory procedures; national survival training; and recreation. More than half of the course is spent learning and practising clinical and laboratory procedures which stand the cadet in good stead for his return to university and third year dentistry. The photographs below show this year's second phase cadets at work in the laboratory.



L to R: O/Cdt K Tangen, O/Cdt RWC Adams, O/Cdt RW Chernesky, O/Cdt TC Tervit



L to R: O/Cdt H Griesbach, O/Cdt RH Crowson, O/Cdt JA Mattress, O/Cdt JJP Laporte
Standing L to R: WO2 EB Morse, O/Cdt CJM Boston
O/Cdt RWC Adams, O/Cdt JWC Walls
O/Cdt TC Tervit, O/Cdt RW Chernesky
O/Cdt K Tangen

THIRD PRACTICAL PHASE

Most cadets who have completed the three practical phases of undergraduate training seem to agree that the third practical phase at The RCDC School is the most enjoyable and rewarding of all. The purpose of third phase training is to give cadets specialized training which will enable them to perform their duties efficiently when appointed as dental officers. Briefly, this ten-week training period includes six weeks of practical clinical duties, three weeks learning special to Corps subjects and one week of national survival training.

Again it seems appropriate for the sake of authenticity to quote the words of the 1962 cadets (1) themselves in describing third phase activities. "The cadet will find his third practical phase of training extensive and interesting. The first three weeks are spent in the dental clinic at The RCDC School in Camp Borden. The cadets are divided into pairs which are allotted an operating area and dental equipment. The members of each pair are designated dentist and dental assistant with these positions alternating every other day. As a result the cadet learns the role and responsibilities of assistants so that following graduation he can utilize them to better advantage. During each day four patients are treated by each group, two in

the morning and two in the afternoon. This number of patients per day increases the operating speed of the student who is accustomed to working on two patients a day at university. Furthermore, the RCDC is equipped with the most up-to-date dental equipment including airtors, high vacuum aspirators and x-ray machines to ensure the best diagnosis and treatment for the patient.

The next four weeks are spent taking lectures in national survival training and RCDC administration. This is followed by a series of dental lectures encompassing the fields of operative dentistry, crown and bridge, complete denture prosthesis, surgery, radiology and endodontics. These lectures are given by well-qualified graduates as at university but the atmosphere is more relaxed and similar to post-graduate study. Each lecture series is given by an officer with advanced training in that field of dentistry so that the information is well organized and presented in an interesting manner.

The social and sports activities are as exhaustive as the more serious side of the third practical phase. If on sports afternoon the cadet is not playing organized baseball or volleyball with the officers and sergeants, he might be found relaxed in the sun at Wasaga Beach. In addition, there are two golf courses and facilities at the officers' mess for tennis, volleyball and billiards. The climax of the summer social activity is the cadets' dance held in conjunction with the Medical Corps.

The third phase student cannot help but end his practical training impressed by the modern ideas of the officers of the RCDC. Undoubtedly the Corps seems to be the ideal niche to practise ideal dentistry."

Photographs of the 1962 third phase cadets at work and at play are shown below and on the following page. It is evident that they enjoyed both.



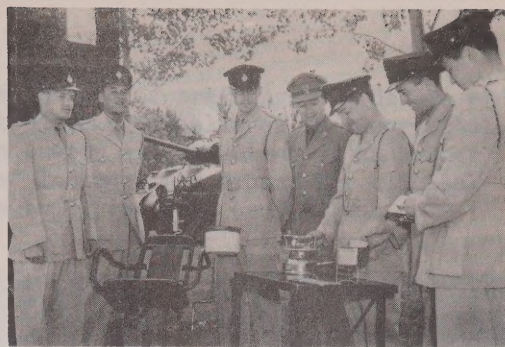
CLINICAL PHASE TRAINING AT THE RCDC SCHOOL

In the foreground Major DH Protheroe is seen instructing a group of candidates.



National Survival Training

L to R: O/Cdt RT Mori, O/Cdt PR McQueen, Lt Col WR Thompson (Instructor), O/Cdt RWR Horn, O/Cdt PS Wede



Familiarization with Field Dental Equipment

L to R: 2/Lt JL Girard, 2/Lt JMM Houde, Capt LT Archambault, 2/Lt JLJ Giguere, 2/Lt J Charron, 2/Lt JML Rochefort, 2/Lt GE Brissette



Study Periods in the School Library

L to R: 2/Lt JML Rochefort, O/Cdt PR McQueen, O/Cdt LW Armstrong, 2/Lt JMM Houde, Capt LT Archambault, 2/Lt JL Girard



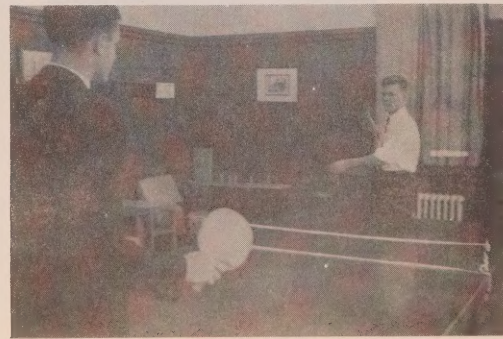
Instruction on Equipment Maintenance

L to R: WO2 EC Carpenter, 2/Lt J Charron, O/Cdt RM MacDonald, O/Cdt RT Mori, O/Cdt WR Kyle, 2/Lt GE Brissette



Recreation

L to R: O/Cdt RT Mori, 2/Lt CM Mason, O/Cdt GW Hill



Recreation

L to R: O/Cdt PR McQueen, O/Cdt LW Armstrong

CADET AWARDS

During each of the three practical phases of training, awards are made to the cadets who achieve the highest standard of excellence in theoretical, practical and military endeavour. These awards are comprised of an Honour Cadet Trophy for each phase and the Chief Instructor's Trophy for clinical proficiency in phase three. The winners this year were as follows:



Honour Cadet Trophy
Phase Three
2/Lt CM Mason (Alberta)



Honour Cadet Trophy
Phase Two
O/Cdt H Griesbach (Toronto)



Honour Cadet Trophy
Phase One
O/Cdt IC Wamera (Toronto)



Chief Instructor's Trophy Awarded Jointly to:

2/Lt JMM Houde (Montreal)

O/Cdt RT Mori (Alberta)

CONCLUSION

An attempt has been made to describe the professional, military and recreational activities of subsidized dental students during their summer training in order to provide prospective candidates for the Dental Officers' Subsidization Plan with an insight into the type of summer employment they may expect if accepted into the plan. It is also considered that RCDC personnel should be familiar with this very important Corps activity so that they can properly advise students interested in a career as a dental officer.

Reference

1. O'Hara DR, Horn RWR, Kyle WR and Wade PS, RCDC Dental Officer Training. Unpublished paper submitted during training at The RCDC School.

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POST-EXTRACTION OSTEITIS

Major IAC MacDonald, DDS

The occasional case of extreme post-operative pain of prolonged duration, may rightly be considered one of the most distressing complications associated with the extraction of teeth. This syndrome, commonly referred to as "dry socket", has been described by many different titles and phrases, including sloughing socket, alveolitis, necrotic socket, localized osteomyelitis or osteitis. When communicating with the patient, "loss or degeneration of the blood clot", or "delayed repair of the tooth socket" would appear more acceptable than the term "dry socket" which is now recognized as inadequate in describing this condition.

Regardless of the terminology used, there is a general recognition that this complication is a localized osteitis over which the operator may have little or no control in preventing, nor can its occurrence be considered a reflection on the ability, skill or judgement of the dental surgeon.

Signs and Symptoms

Clinical investigation of patients with post-extraction osteitis usually reveals a variety of signs and symptoms; the main one, of course, being pain which has prompted them to seek help. This pain may be confined to the area of involved bone or radiating in character. Associated with the pain there is usually a foul odour emitting from the socket and an associated soft tissue inflammatory response with possible trismus and cellulitis.

Course of Normal Socket Healing

When a tooth is extracted a sequence of events occurs. The periodontal membrane is torn and there is a rupture of blood vessels. Blood pours into the socket and surrounding tissue and a coagulation process takes place. In this process a fibrin network is laid down entrapping cells and debris. Under normal conditions this clot clings to and protects the walls of the socket. Reparative changes begin with a reaction of the blood vessels. The flow of blood within the vessels becomes slowed followed by diapedesis or migration of leukocytes to the periphery. Blood plasma escapes through the capillary walls producing edema at the periphery of the clot within a day.

This is a typical inflammatory reaction to the injury. At the same time, the capillaries send solid buds of endothelium into the clot which soon develop lumina and become new extensions of the circulatory system. With the development of its own circulation, the clot becomes tissue in the true sense of the word. Fibroblasts enter the clot from the surrounding bone marrow spaces and from the blood vessels of the periodontal membrane that remains attached to the lamina dura. These fibroblasts lay down collagenous fibers and give strength to the new tissue. Simultaneous with the inflammatory changes and organization of the clot, removal of debris takes place. Dead cells, necrotic tissue and foreign material are removed by polymorphonuclear leukocytes and macrophages. In a few days coarse fibrillar bone appears within the collagenous matrix and spreads throughout the entire socket from the base towards the surface and from its periphery to the centre. This is known as immature bone and although the socket appears completely healed clinically, the radiograph will show radiolucency. Three weeks to six months later this immature bone is replaced by well organized mature bone possessing a higher content of calcium salts. In the final stage, the bony trabeculae are laid down in a functional pattern by resorption and deposition so that the outline of the socket is obliterated.

From our review of events that immediately follow tooth extraction, it is quite evident that there are many crucial points at which the orderly course of healing may go astray. It is little wonder that there are so many different and sometimes contradictory theories as to the cause of this departure from the normal healing process.

Etiological Theories

While the causative factors of this unfortunate syndrome are still shrouded in mystery, many ideas have been advanced concerning its etiology. Very few writers appear to agree entirely in this regard. Undue trauma has been frequently mentioned, but how many times has post-extraction osteitis developed following the simple removal of a lower bicuspid? Perhaps the question is - what exactly is undue trauma in a particular case?

The effect of the ephinephrine in the anaesthetic solution on the local circulatory function has been mentioned but then again the condition has been observed following extraction under general anaesthesia. There are also those who blame the poor oral hygiene of the patient, yet it will be recalled that the human mouth builds up a high degree of immunity to its own bacterial flora and, statistically, the incidence of the occurrence is not overwhelming on the side of neglected mouths.

Some writers feel that the patient's general resistance to infection is an important factor and advise vitamin therapy. Many others have felt that the age or general condition of the patient has little or nothing to do with post-extraction osteitis but that it is a purely local affliction and, therefore, treatment should be local.

Contributing Factors

According to information appearing in the literature, it would seem that there are several factors to be considered which will vary in significance with each and every case. Some of the conditions which may contribute to post-extraction osteitis are listed hereunder:

1. General systemic factors

- a. Age of the patient
- b. Nutrition
- c. Sclerotic bone
- d. Systemic diseases

2. Local trauma

3. Absence of blood clot

4. Micro-organisms

5. Foreign bodies and diseased tissue

1. General systemic factors

- a. Age - It is generally accepted that the older the patient, the greater are his chances of developing a complication following extraction. This acceptance is based on the predication that the young patient has a greater potential for producing active vigorous reparative tissue whereas the older patient, is in a balanced metabolic or catabolic state and his reserve of new growth potential is more likely to be lacking.
- b. Nutrition - There is a constant body need for all the dietary elements in order to maintain health and this requirement increases following injury and infection. Proteins, in particular, are very necessary for the fibroblastic and osteoblastic phases of wound repair. Experiments have shown that there is an increased fibroblastic activity in optimum protein diets and the converse is true in protein deficiency. Archer⁽¹⁾ reports investigations where it has been shown that pregnant women are less prone to post-extraction osteitis than non-pregnant women. This is believed due to the increase in globulin, which is a serum protein, from 0.2 per cent in the non-pregnant woman to 0.4 per cent in the pregnant woman. Absence or diminution of the gamma globulin fraction of the blood results in a significant reduction in circulating antibodies and an increased susceptibility to infection.
- c. Sclerotic bone - The presence of a very dense lamina dura of the socket with its small blood supply is regarded as a contributory factor. Some authors recommend drilling holes in the lamina dura in an effort to encourage fresh haemorrhage for nourishment of the clot. This is not considered to be good practice as the danger of introducing bacteria into bone is thus increased.
- d. Systemic diseases - It is generally accepted that a number of systemic diseases will contribute to slow healing of wounds. Diabetes is a very common one as is anaemia because of the decreased oxygen-carrying capacity of the haemoglobin. Any of the blood dyscrasias which exhibit delayed bleeding or clotting can influence greatly the formation and effectiveness of the blood clot.

2. Local trauma

Of all the contributing factors mentioned in the literature, none receives as much consideration as local trauma. The traumatic factor is linked with the blood supply and the fibroblasts that are necessary for the repair

at the extraction site. Excessive instrumentation and force burnish the walls of the alveolus and damage the blood vessels present in the periodontal membrane. This results in an inadequate blood supply which initiates a vicious cycle of events.

3. Absence of blood clot

Primary bleeding usually subsides two to five minutes after the rupture of the vessels of the periodontal membrane. If this clot is washed away by excessive flushing of the socket another clot may not form. Furthermore, a well-developed clot may be dislodged when the sponge pack is removed by the patient.

4. Micro-organisms

As stated previously, the mouth has "built-in" resistance to the bacteria of the oral cavity. Danger of infection occurs when the area is inoculated with foreign organisms by such means as non-sterile instruments, sponges or unclean hands.

5. Foreign bodies

Pieces of calculus, tooth, and filling material may delay the healing due to their presence as the foreign bodies. The resulting inflammation interferes with the organization of the clot.

Diagnosis

The diagnosis of post-extraction osteitis is entirely clinical. The patient usually returns from 2 - 10 days following the surgery and complains of a throbbing or pounding pain. This pain is usually severe and is frequently manifested in the region of the ear as well as the extraction site. A putrefying odour is invariably present although the patient may not be aware of it. On examination, he may or may not have a slight temperature, swelling of the jaw and accompanying lymphadenitis. The socket may be completely devoid of a clot but if one is present it is usually greyish in colour. In the early stages, when diagnosis is more difficult, the clot may appear quite normal on the surface but if probed, the instrument used meets with no resistance and causes increased pain if allowed to touch the walls of the socket. The deeper structures of the clot are a dark colour and frequently give off a foul odour. The clot, once disturbed, is quite easily removed by gentle cleansing with absorbent cotton and warm saline irrigation.

Treatment

The many forms of therapy suggested for the treatment of post-extraction osteitis testify that there is no one specific method that will cure the condition in a single treatment.

1. Pre-operative and preventative measures

- a. The use of antibiotics systemically or locally may warrant some consideration. It is this writer's opinion, however, that routine pre-operative use of antibiotics in a healthy, comparatively young individual is to be discouraged. Even in cases where infection is present, it is felt that once the source is removed, the defensive mechanisms of the body can quite readily cope with the situation, thus reserving the antibiotics for a time when they are really needed.

- b. Extraordinary care should be employed at all times to minimize trauma. The soft tissues should be carefully reflected where elevators are to be used. One should never hesitate to reflect a flap with a good broad base and remove adequate cortical bone to facilitate easy removal.
- c. In cases where the socket does not appear to fill rapidly with blood and form a clot following surgery, it may be advisable to pack the socket immediately with a loose fitting dressing or plug made of periodontal pack. This will allow a much smaller area between the dressing and bone for the organization of the clot. It also has an anodyne effect thus minimizing normal post-operative pain.
- d. It is recommended that the patient be given written instructions regarding home care immediately following extraction.

2. Post-operative

Possibly the first and most important post-operative measure in treatment is early detection. Therefore, the patient should be seen routinely within 48 hours following surgery. If complications are detected, the condition should be clearly explained and treatment commenced to shorten the period of discomfort. The clot is gently probed and, if found necrotic, the socket should be irrigated thoroughly with warm water and any loose fragments carefully lifted out with cotton pliers or small curettes. If the dentist can detect that degeneration of the clot is going to take place, he can relieve the patient of considerable pain by beginning treatment at once. The area is isolated with cotton rolls and the socket gently dried. An anodyne dressing of choice is then inserted and left in place for 24 - 36 hours after which it is replaced by a second dressing. Successive dressings are inserted at longer intervals to keep the socket free from debris despite the fact that the patient may have complete comfort in the later stages. It is important to remember not to pack the dressing tightly into the socket and to ensure that the tip of the dressing is carried to the apical portion.

Conclusion

Post-extraction osteitis is a painful syndrome in which the blood clot disintegrates leaving unprotected bone. It can be compared to the common cold in that there is no known positive curative treatment but some form of palliative therapy is necessary and helpful. The dentist's primary objective should be to eliminate pain, promote healing and prevent further infection.

Reference

Archer, W.H. - Oral Surgery, Third Edition 1961

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In Canada the incidence of intraoral cancer is about 4.0 per 100,000 population for males and 1.2 per 100,000 for females. Of all cancer deaths in Canada, intraoral cancer accounts for 3% in males and 1.1% in females.

(From an article "Twenty-five Year Study of Oral Cancer" published in Dental Abstracts, Vol 7, No 9)

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COMBINATION CLASPS IN PARTIAL DENTURE CONSTRUCTION

Lt Col SG Bagnall, CD, DDS

Over the years many authorities have described the advantages of using a wrought wire retentive arm in combination with a cast clasp. The chief advantage described by employing this technique is the stress breaking flexibility which makes it particularly suitable for free-end saddles or on a weak abutment tooth. In addition it remains adjustable after completion and may be adjusted at a later date to increase or decrease retention as may be required. It has also been described as having both esthetic and hygienic advantages over cast clasp arms. Bearing in mind the present day concept of minimum, rather than maximum retention in a partial denture, the use of a combination clasp will occasionally be indicated.

The extra steps involved in fabrication were earlier described as its chief disadvantage and the requirement to solder endangered the physical properties of the wire. Recently, the manufacturers of "Ticonium" produced a chrome cobalt wire which can be incorporated in the wax-up. This wire is then mechanically retained in the completed denture and does not require the use of solder.

Denture wax-up is completed in the normal manner. An appropriate length of 18-gauge round Ticonium wire is then shaped to form a retentive arm, luted to the wax and invested for casting.

The manufacturer recommends the following steps in the laboratory procedure:

1. Determine the length of wire needed by adapting a 14-gauge round wax shape to the abutment tooth. Straighten out and cut a piece of wire to that length.
2. With pliers, make a right angle bend approximately 2mm from the end of the wire. This forms the "foot" which will be imbedded in the casting for mechanical retention.
3. Lay wire, with foot resting on ridge area of cast, against the minor connector leading to occlusal rest. Make a pencil mark on the wire just below the marginal ridge and occlusal rest. This will determine the length of the vertical portion of the wire.
4. With the Dixon pliers, make an acute bend, forming an angle less than 90 degrees. Whether this bend is made to the buccal or lingual will depend on which tooth surface is to be retentive. Usually, however, this will be toward the buccal surface.
5. After making this second bend, try the wire against the minor connector or guiding plane surface to be sure that the angle of the bend still lies below the occlusal rest.
6. A third bend is then made which actually is an adaptation to the contour of the abutment tooth, thus beginning the clasp arm proper. Unless this is done accurately prior to casting, a space between the origin of the clasp arm and the abutment tooth will exist which cannot be corrected by later bending, due to the fact that it is held rigidly by the casting.

7. The wrought wire is now imbedded into the center of the waxed minor connector and held in place against the abutment tooth so that no space exists. This is done by slightly warming the wire, taking care not to have it hot enough to cause the wax to flow. (If this should occur, a film of fluid wax will be drawn beneath the wire, which will result in a thin "shim" of cast metal between the wrought wire and the abutment tooth and which would interfere with the contouring of the wrought retentive arm.)
8. All of the wrought wire but the clasp arm proper is covered with a film of wax, so that at no point will the wrought wire block the flow of molten metal. The remainder of the wrought retentive arm which will be adapted later will extend out into space, to be held by the investment during casting.
9. After this has been done for all abutment teeth, the waxed framework is ready to be invested and cast.

Polishing and Finishing:

When sandblasting and Ti-Lectro polishing (whether with Ticonium wire or PGP), cover wire with a coat of high fusing wax to prevent etching. Use a rubber point lightly to remove any oxide. A bristle brush on a low speed motor is recommended.

FORMULAE AND TECHNIQUE FOR REDUCING AND INTENSIFYING RADIOGRAPHS

WO2 Sherry JM

Established methods of exposure and processing routinely produce radiographs of good diagnostic quality. However, there are times when radiographs do not meet the required standard. This usually happens when it is not convenient to bring the patient back for more "retakes". The following techniques and formulae for reducing and intensifying are being used here with good results.

The solutions used by this writer are prepared according to the standard formulae reported by Simpson⁽¹⁾ as early as 1930. These formulae are just as effective today as they were at that time, despite the improvements in X-ray film.

The solutions are compounded as follows:

A. REDUCING SOLUTION FORMULAE

STOCK SOLUTION A

Sodium Cyanide 65 grs
Water qs ad 32 ozs

STOCK SOLUTION B

Iodine 45 grs
Potassium Iodide .. 80 grs
Hist. aqua qs ad .. 1 oz

These two stock solutions are mixed in a ratio of 1 oz of Solution A to 20 drops of Solution B.

B. INTENSIFYING SOLUTION FORMULA:

Potassium Iodide 16 ozs
Mercuric Iodide 80 grs
Hypo 5 grs
Water qs ad 16 ozs

REDUCING TECHNIQUE:

Films should be well washed after fixation, or if already dry, washed for five minutes prior to reducing. A granite-ware pan 16" square, in which the receptacles may be placed, is an aid in confining any solution or water which may be dropped during the operation. The stock reducing solution is mixed (1 oz of "A" to 20 gtt of "B") in a small dish and applied with a pledget of cotton tightly rolled on a wooden applicator. If the general density of the negative is too great, the film can be submerged in the solution for periods of one to five seconds to obtain the desired density of shadows before reduction of the highlights are begun. To stop the action of the reducer, the film is dipped in water.

For local reduction, the film, emulsion side upward, is held so that the solution will flow toward the area requiring this action. This flow may often be regulated by gently curving the film to produce a concavity at the desired location by pressure of the thumb and finger on opposite edges of the film and should always be held in this manner to avoid distorting the softened emulsion. After reduction, the film is washed for five minutes in running water to remove the reducing solution. It must be remembered however that after fixation of any film the total "washing time" and "after reduction washing time" must be at least twenty minutes to remove the sodium thiosulfate fixer. (2)

The reducing solution should be freshly mixed for use but as the action slows a few drops of solution "B" can be added.

INTENSIFYING TECHNIQUE:

The intensifying solution is used in the following manner. After the negative is fixed and washed, it is placed in the solution for a short period of time ranging from a few seconds to a minute depending upon the amount of intensification desired. It is then placed in a slow developing solution for three minutes to clear and fix the image. A small quantity of developing solution placed in a separate container may be used for this purpose and then discarded. The film is then washed in running water for the normal period.

POSSIBLE COMPLICATIONS

It is important to note that sodium cyanide is highly poisonous either by absorption in the mouth or to a lesser degree by inhalation. The solution does not affect the skin unless the user has a susceptibility to iodine. Caution is indicated in the handling of this drug. Hands and utensils should be thoroughly washed and the "no smoking" edict should be observed due to high volatility of the sodium cyanide.

SUMMARY:

A technique and the formulae for reducing and intensifying dental radiographs has been outlined. This technique is simple and its use will often eliminate additional radiation exposure necessitated by the need for "retakes".

REFERENCES:

1. Simpson, C.O. The Technique of Oral Radiography, St. Louis, Mosby, 1930. p. 181.
2. McCall and Wald, Clinical Dental Roentgenology, Phil. Pa. Saunders, 1958. p. 131.

THE SURGICAL CORRECTION OF PERIODONTAL POCKETS TO ACHIEVE OPTIMAL PHYSIOLOGICAL FORM OF THE PERIODONTIUM

Capt DG Gardner, DDS

Pocket eradication consists of reducing the depth of the periodontal pocket to that of a physiological sulcus. It is, however, only one part of periodontal therapy and should not be considered an end in itself. The basic guiding concept here is that the therapist is first treating a patient who has, as one facet of his make-up, periodontal disease. In turn, periodontal disease is only one aspect of the patient's oral condition. Finally a local area of periodontal pockets is only a part of the overall periodontal condition of the patient. The dentist must therefore consider "the whole patient concept" and "the whole mouth concept". Bearing this in mind, the ultimate goal as far as the periodontal phase of treatment is concerned, is the cessation of pathological destruction of the periodontium and the maintenance of periodontal health.

Scaling and Curettage or Surgery

There are two main methods for the local treatment of periodontal pockets:

Scaling and Curettage; and
Surgical - including gingivectomy, flap operations, alveolar bone contouring, electrosurgery, chemosurgery and extraction for periodontal reasons.

Scaling and curettage is, in itself, a surgical procedure. However it is normally considered apart from those listed here as surgical methods. Scaling and curettage is the method of choice if the periodontist feels that the required result can be obtained in this manner. If this method will not suffice, or if it has already failed, he may turn to the surgical techniques. This decision depends upon a proper sequence for the approach to any periodontal problem. One such sequence might be:

Examination;
Treatment of acute conditions;
Possible gross scaling;
Diagnosis, prognosis and treatment planning;
Presentation of proposed treatment to the patient;
Pocket eradication;
Patient education and oral physiotherapy instruction; and
Other periodontal and operative procedures.

One important factor which affects the choice between scaling and curettage, and surgical methods is aesthetics, especially in the maxillary anterior region.

Optimal Physiological Form of Periodontium

In order to treat the diseased periodontium effectively, the dentist must have a clear idea of the ultimate goal. Clinically, the ideal is the familiar pink, stippled gingiva with its cone-shaped papillae, well adapted knife-edged margins, gingival sulci of $\frac{1}{2}$ -1 mm and normal interdental grooves. In addition, the gingiva does not bleed when touched and is self-cleansing. Recession, although not desirable, may be present. However, the gingiva should have the same physiological form, albeit at a more apical level.

Architecture of the Alveolar Bone

It is noteworthy that pockets tend to develop more often in the interdental area than either buccally or lingually. The interdental bone is therefore presumed to be the weakest spot, the prime target of periodontal disease.

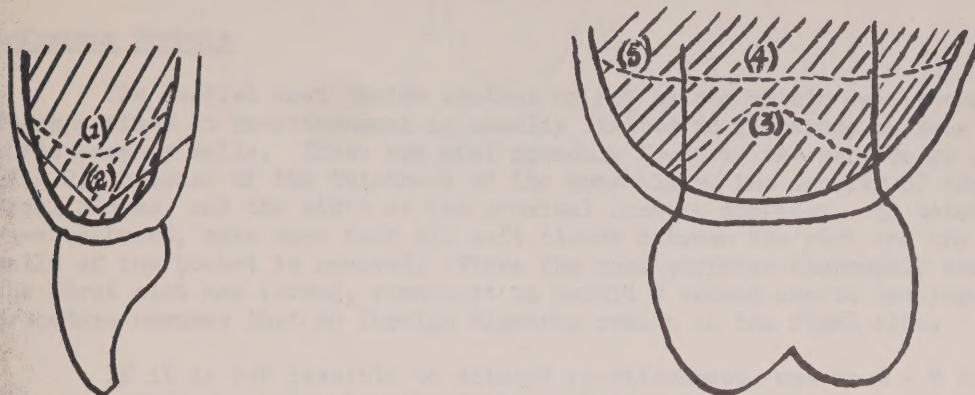


Fig.1

Fig 1 shows the normal interdental bony architecture. In the anterior region it is conical; in the posterior region it is spherical. Theoretically, bone loss in the anterior region alters the bony contour little - it remains conical (1). A simple gingivectomy, using a long bevelled incision, (2) should, therefore, re-establish the optimal form of the gingiva because the architecture of the underlying bone is also still optimal. In practise, however, such a regular resorption is rare and some contouring of the alveolar bone is necessary in many cases of gingivectomy in the anterior region.

In the posterior region the bony resorption results in interproximal craters (3), blunted interproximal cones (4), and thick buccal or lingual ledges in the marginal areas (5). These are the three most common osseous deformities in this region. Under these circumstances a simple gingivectomy could never result in the desired form of the gingiva because the underlying bony topography is no longer optimal, thus if proper physiological form of the periodontium is to be obtained, recontouring of the bony architecture is necessary.

Treatment

Simply stated, the technique described in this article could be called "gingivectomy with bone contouring".

Use block or infiltration anaesthesia and inject into each interproximal papilla. This helps to control the haemorrhage and makes the gingiva more rigid and easier to cut.

Perform a routine gingivectomy to the crest of the bone and remove all the granulation tissue from the interproximal areas. This assists in reducing the bleeding as granulation tissue is very vascular.

Scale the roots very thoroughly, irrigate and dry the area.

Using a periosteal elevator, ease back the gingiva from the bone. Examine the anatomy of the bone for interproximal craters or

or infrabony pockets, blunted interproximal crests and thick buccal or lingual ledges. If the bony topography is satisfactory, the operation is complete and a surgical pack may be placed. If, however, any of these defects are discovered, a flap must be raised and steps taken to **re-establish** the optimal bony architecture.

1. Infrabony Pockets

The dentist must decide whether or not he can obtain re-attachment. Therapy aimed at re-attachment is usually limited to infrabony pockets with three osseous walls. These are most commonly found in the mandibular area (Fig 2), because of the thickness of the bony ridge, the density of the cortical plates, and the width of the proximal contact surfaces. In attempting re-attachment, make sure that all soft tissue between the root and the osseous walls of the pocket is removed. Plane the root surfaces thoroughly and after the first clot has formed, remove it to permit a second one to develop. This procedure ensures that no foreign elements remain in the final clot.

If it is not feasible to attempt re-attachment, use No 6 - 8 round burs to remove the lateral wall of the pocket.

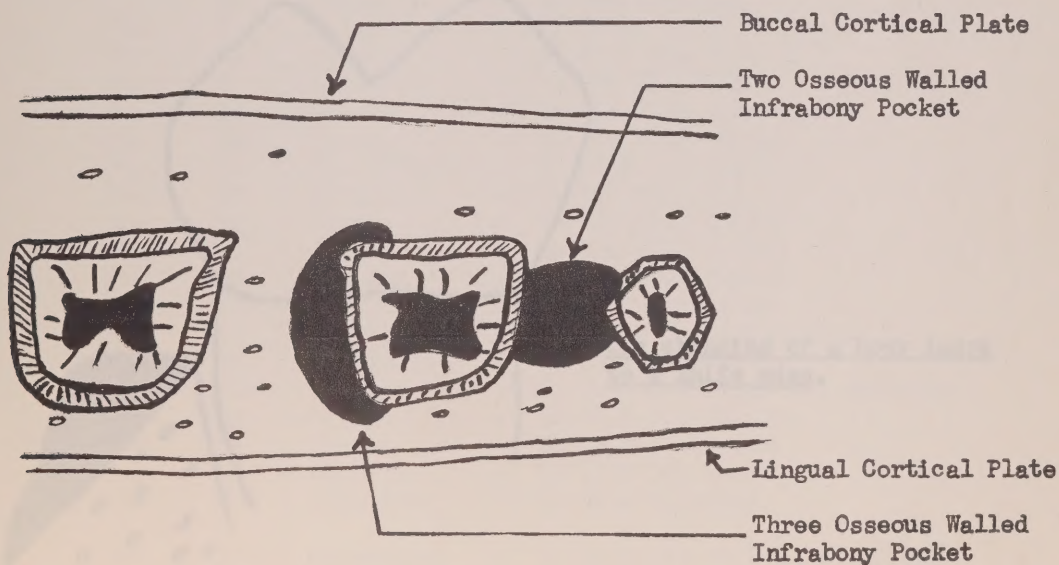


Fig. 2

2. Other Bony Defects

The other bony defects are treated by using a round bur to cut interdental and interradicular grooves, to obtain the spherical or conical shape of the interdental cones, and to change ledges to knife-edges (see Figs 3 and 4). An attempt is made to obtain a scalloped effect.

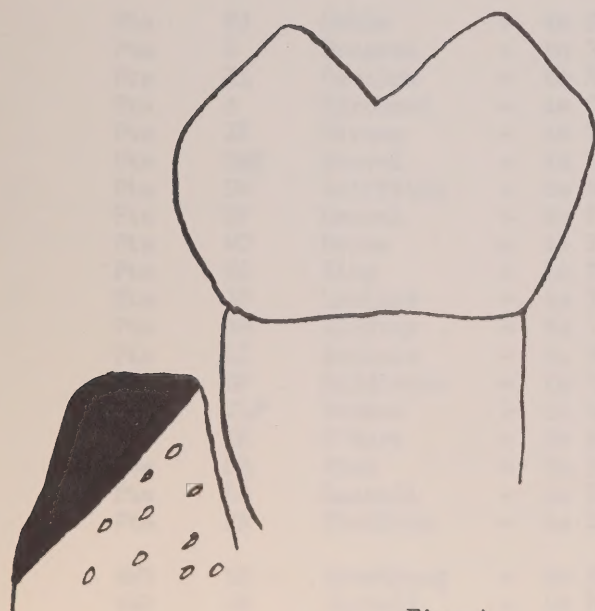
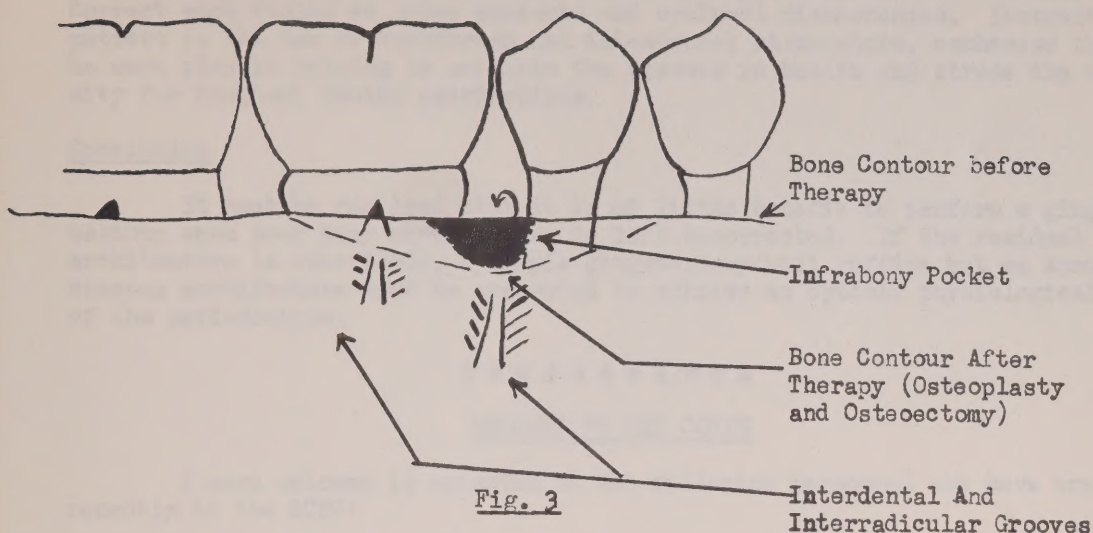


Fig. 4

The treatment for bifurcation and trifurcation involvements depends upon the degree of bone loss. If it is minimal, all that may be required is a recreating of the interradsular groove; if it is more marked, then the interradsular regions must be curetted out. This altering of the bony architecture is called osteoplasty when no supporting bone is removed and osteoectomy, if supporting bone is removed. The basic concept to be remembered in the treatment of these conditions is that the dentist should attempt to create a physiologic pattern which resembles the normal bony architecture even though it is in a more apical position in relation to the teeth.

Following surgical intervention, replace the flap and insert a periodontal pack. Remove the pack after one week and inspect the area thoroughly. Eliminate any small pieces of calculus which have been missed at the time of the surgery and re-pack the region if necessary.

When the area is healed, polish the clinical crowns of the teeth using periodontal files, polishing strips interdentally, and pumice on a rubber cup. Correct such faults as loose contacts and occlusal disharmonies. Instruct the patient in the use of toothbrush and interdental stimulators, emphasize the part he must play in helping to maintain the tissues in health and stress the necessity for frequent dental examinations.

Conclusion

It must be realized that it is of little benefit to perform a gingivectomy when poor bony architecture is left uncorrected. If the residual bony architecture is acceptable, a simple gingivectomy will suffice but an abnormal osseous architecture must be corrected to achieve an optimal physiological form of the periodontium.

WELCOME TO THE CORPS

A warm welcome is extended to the following personnel who have transferred recently to the RCDC:

Pte	NJ	Cable	-	to FOB Winnipeg
Pte	G	Drapeau	-	to 3 Det RCAMC Quebec
Pte	RA	Garnhum	-	to RCAF Stn Trenton
Pte	A	Girouard	-	to CFH Kingston
Pte	JF	Giroux	-	to The RCDC School
Pte	GMR	Gravel	-	to The RCDC School
Pte	DW	Griffiths	-	to RCAF Stn Namao
Pte	BF	Hannah	-	to FOB Winnipeg
Pte	WD	Horne	-	to The RCDC School
Pte	HC	King	-	to The RCDC School
Pte	JP	Lambert	-	to The RCDC School
Pte	RS	Lindsay	-	to 7 PD London Ont
Pte	LI	MacLean	-	to HQ BC Area Vancouver
Pte	DF	Middleton	-	to Camp Gagetown
Pte	JLP	Nadeau	-	to No 1 Dent Eqpt Dep Petawawa
Pte	TR	O'Mara	-	to RCAF Stn Trenton
Pte	LH	Pion	-	to HMCS Stadacona
Pte	LA	Russell	-	to RCAF Stn Moose Jaw
Pte	JH	Thorburn	-	to Camp Gagetown
AW2	RD	Armstrong	-	to RCAF Stn Portage la Prairie
AW2	AM	Burdell	-	to RCAF Stn Namao
AW2	SJD	Clutterbuck	-	to RCAF Stn St Hubert
AW2	EL	Gunville	-	to RCAF Stn Camp Borden
AW2	MA	Lawrence	-	to RCAF Stn Camp Borden
AW2	SC	MacDonald	-	to RCAF Stn Winnipeg
AW2	JE	Patterson	-	to RCAF Stn Trenton
AW2	JE	Richardson	-	to RCAF Stn Cold Lake
AW2	DN	Scarborough	-	to RCAF Stn Bagotville
AW2	JM	Scott	-	to RCAF Stn Trenton
AW2	LS	Seraphin	-	to RCAF Stn Camp Borden

PROMOTIONS

Congratulations are extended to the following officers and men on their recent promotions:

Major	WR	Thompson	- to Lt Col
Capt	HG	Bunston	- to Major
Ssgt	HJ	Stokes	- to WO2
Sgt	EE	Mazerall	- to Ssgt
L Sgt	JG	Moore	- to Sgt
Cpl	JWW	Broomfield	- to Sgt
Cpl	AL	Strub	- to Sgt
Pte	TJ	Deloughery	- to Cpl
Pte	JAY	Ferland	- to Cpl
Pte	BA	Green	- to Cpl
Pte	RB	Johnson	- to Cpl
Pte	DL	Kerr	- to Cpl
Pte	JM	MacLean	- to Cpl
Pte	OW	Mandrusiak	- to Cpl
Pte	IA	Mason	- to Cpl
Pte	PA	McCoy	- to Cpl
Pte	PD	Peterson	- to Cpl

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RETIREMENTS

Our best wishes for a happy retirement are extended to the following personnel who have given many faithful years of service to the Corps:

Lt Col	AR	Smith	- RCAF Stn St Jean
WO2	JM	Jones	- The RCDC School
Sgt	GW	Blanke	- 15 Dent Coy
Sgt	GS	McConnell	- 12 Dent Coy
Sgt	V	Krymlek	- 11 Dent Coy

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RELEASES

The following personnel have taken their release and with them go our best wishes for future success:

Capt	TM	Johnston	- The RCDC School
Capt	FW	Lovely	- 12 Dent Coy
Sgt	WH	Fougere	- 12 Dent Coy
Cpl	WW	Webster	- 11 Dent Coy
Cpl	JA	Rathe	- 35 Fd Dent Unit
LAW	MBA	Perusse	- 11 Dent Coy
LAW	MH	Schmidt	- 12 Dent Coy
LAW	LA	Van der Stap	- 15 Dent Coy
AWL	DT	Lawrence	- 13 Dent Coy

Cpl RJE Lalonde has recently been released from the Corps to the National Defence Medical Centre (DVA) for continuing treatment. It is our sincere hope that he will regain good health in the near future.

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The following postings have been effected since the last issue of the Quarterly:

Major	C	Brown	- to Ft Beausejour from Ft Prince of Wales, 4 Fd Dent Coy
Major	HG	Bunston	- to RCAF Stn Greenwood from HMCS Shearwater
Major	AG	Taylor	- to HMCS Shearwater from HMCS Bonaventure
Capt	MA	Abramson	- to HMCS Shearwater from HMCS Cornwallis
Capt	FC	Arpin	- to HQ 15 Dent Coy Montreal from CBUME
Capt	JOL	Bourget	- to CBUME from CJATC Rivers
Capt	DS	Campbell	- to CFH Halifax from HMC Dockyard Halifax
Capt	WR	Collier	- to 4 Fd Dent Coy from Whitehorse
Capt	GT	Crossman	- to RCAF Stn Greenwood from 4 Fd Dent Coy
Capt	WJ	Froese	- to Ft Churchill from HQ Manitoba Area
Capt	LC	Gray	- to RCAF Stn Vancouver from HQ BC Area
Capt	Y	Kamachi	- to RCSME Vedder Crossing from HMCS Naden
Capt	VD	Kvedaras	- to RCAF Stn Clinton from RCAF Stn Trenton
Capt	RJ	Paturel	- to RCSME Vedder Crossing from HQ Ft Churchill
WO2	VO	Blackmore	- to FOB Winnipeg from Whitehorse
WO2	SL	MacLean	- to HMCS Shearwater from HMC Dockyard Halifax
WO2	HJ	Stokes	- to HQ 15 Dent Coy Montreal from HMCS Naden
Ssgt	SM	Toole	- to HMCS Naden from Workpoint Bks Esquimalt
Ssgt	CR	White	- to QM Stores Calgary from RCAF Stn St Jean
Sgt	M	Beauvais	- to RCAF Stn Camp Borden from The RCDC School
Sgt	KPH	Buchholz	- to RCAF Stn Winnipeg from Ft Churchill
Sgt	MG	Dean	- to HMC Dockyard Esquimalt from HMCS Naden
Sgt	JRA	deBlois	- to No 6 RD Trenton from RCAF Stn Goose Bay
Sgt	AS	Field	- to RCAF Stn Clinton from HMCS Stadacona
Sgt	DLG	Flesher	- to DGDS Ottawa from No 4 Fd Dent Coy
Sgt	P	Fox	- to CBUME from HMCS Naden
Sgt	SG	Fraser	- to HMCS Bonaventure from HMCS Stadacona
Sgt	FG	Grundy	- to HMCS Stadacona from HMC Dockyard Halifax
Sgt	DF	Hill	- to RCAF Stn Summerside from 4 Fd Dent Coy
Sgt	J	Hossdorf	- to No 4 Fd Dent Coy from Calgary
Sgt	FK	MacKay	- to HMCS Shearwater from HMCS Bonaventure
Sgt	GE	McGunnigal	- to RCAF Stn Moose Jaw from Camp Shilo
Sgt	JG	Moore	- to 4 Fd Dent Coy from HQ 11 Dent Coy Edmonton
Sgt	DB	Playford	- to Ft Churchill from RCAF Stn Camp Borden
Sgt	WS	Richardson	- to RCAF Stn Goose Bay from RCAF Stn Camp Borden
Sgt	AL	Strub	- to No 1 Dent Eqpt Dep Petawawa from CBUME
Sgt	GH	Taylor	- to Whitehorse from Calgary
Sgt	RL	Thornton	- to Whitehorse from Griesbach Bks Edmonton
Sgt	HD	Wagstaff	- to The RCDC School from HMCS Cornwallis
Sgt	DB	Wood	- to No 35 Fd Dent Unit from Whitehorse
Sgt	JR	Yeates	- to HQ 14 Dent Coy from FOB Winnipeg
L Sgt	JC	Bleakney	- to HMCS Bonaventure from HMC Dockyard Halifax
L Sgt	PJ	Dumas	- to CBUME from No 1 Dent Eqpt Dep Petawawa
Cpl	JIJ	Boulanger	- to Longue Pointe from CBUME
Cpl	WE	Bussell	- to RCAF Stn Winnipeg from FOB Winnipeg
Cpl	JRM	Chayer	- to RCAF Stn St Jean from CMR St Jean
Cpl	PAP	Hughes	- to HMC Dockyard Halifax from HMCS Shearwater
Cpl	AF	Randall	- to HMC Dockyard Halifax from HMCS Stadacona
Cpl	G	Sapergia	- to RMC Kingston from Camp Picton
Pte	RS	Black	- to HMCS Cornwallis from Camp Gagetown
Pte	HL	Boring	- to RCSME Vedder Crossing from Griesbach Bks
Pte	RJ	Forward	- to RCAF Stn Uplands from RCAF Stn Trenton
Pte	B	Hannay	- to Calgary Bks from RCAF Stn Cold Lake
Pte	HH	Nogler	- to RCAF Stn Greenwood from HMCS Bonaventure

POSTINGS (Cont'd)Airwomen

Sgt	MP	Foley	- to RCAF Stn Camp Borden from RCAF Downsview
Cpl	KP	Palmer	- to 3 (F) Wing from 2 (F) Wing, 35 Fd Dent Unit
LAW	AC	Perrier	- to RCAF Stn Comox from RCAF Stn St Hubert
LAW	MR	Thibault	- to 35 Fd Dent Unit from RCAF Stn St Hubert
LAW	LP	Yakemchuk	- to RCAF Stn St Hubert from RCAF Stn Parent
AW1	SJ	McMillan	- to RCAF Stn Goose Bay from RCAF Stn Lac St Denis
AW1	DJM	McNichol	- 35 Fd Dent Unit from RCAF Stn Rockcliffe
AW2	CM	Fraser	- to RCAF Stn Trenton from 6 RD Trenton

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TRAINING

During the period since the last issue of the Quarterly, Corps personnel have undertaken a variety of training as follows:

Royal College of Surgeons, London, England - General Oral and Dental Surgery - 22 Oct - 14 Dec 62

Major	LA	Richardson
Major	FD	Charman

US Naval Dental School, Bethesda, Md - Crown and Bridge - 15 Oct - 27 Nov 62

Major	AG	Taylor
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RCDC School Courses

Capt to Maj Qualifying - 17 Sep - 26 Oct 62

Capt	LJE	Bosse
Capt	JF	Eadon
Capt	RH	Headley
Capt	WB	Hudgins
Capt	JH	Marion
Capt	HK	Meisner
Capt	LA	Reynolds

Technical Dental Therapist - 3 Sep - 7 Dec 62

WO2	TL	Batten
WO2	RH	Daw
WO2	H	Thorsson

Dental Technician Laboratory Group 4 - 17 Sep - 26 Oct 62

Sgt	WJ	Arnsby
Sgt	JA	Christiansen
Sgt	FG	Grundy
Sgt	DF	Hill
Sgt	AJ	Hughes
Sgt	FM	Kennedy
Sgt	GF	Keogh
Sgt	KS	Rothwell
Sgt	G	Shechosky
Sgt	RL	Thornton

Dental Assistant Group 1 - 9 Oct - 9 Nov 62

Cpl	JRR	Roy
Pte	JB	Arsenault
Pte	N	Cable
Pte	DJ	Davies
Pte	GN	Fathers
Pte	RJ	Forward
Pte	RA	Garnhum
Pte	JRY	Gratton
Pte	B	Hannay
Pte	DH	Hardy
Pte	GED	Hayes
Pte	TJ	Herrett
Pte	WD	Horne
Pte	DF	Ife
Pte	C	Lachance
Pte	DK	Mand
Pte	RG	Moffat
Pte	LG	Peverill
Pte	OR	Sorensen
LAW	SS	Fitzpatrick
AW1	HL	Brooker
AW1	ME	Koch
AW1	JM	Roberts
AW1	SM	Thiele
AW2	I	Gruener

No 1 Dental Equipment Depot CoursesDental Equipment Repairer Group 1 - 24 Sep - 14 Dec 62

Cpl	EA	Duve
Pte	PD	Whynott

Dental Storeman Group 1 - 10 Sep - 19 Oct 62

Cpl	RW	McDonald
Pte	JLP	Nadeau

CFMSTC Camp Borden - First Aid Instructor Tri-Service Course -
10 Sep - 5 Oct 62

WO2	JE	Shiner
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RCASC School Camp Borden - Sr NCO Course3 Sep - 26 Oct 62

A/Sgt	HK	Drawe
A/Sgt	EPH	Sprathoff

10 Sep - 2 Nov 62

Cpl	EB	Borden
Cpl	N	Demedash
Cpl	ADT	Gardner
Cpl	WG	Harmer

Command Junior NCO Courses

Pte	BA	Green
Pte	OW	Mandrusiak
Pte-	PA	McCoy
Pte	DH	McKay

VITAL STATISTICSDIRECTORATEMarriage

Mr Dennis Robillard was married to Miss Fleurette Traversy at Eastview, Ont on 8 Oct 62.

RCDC SCHOOLBirths

To Ssgt and Mrs GEC Bradley, a daughter, on 5 Oct 62.

11 DENT COYBirths

To Capt and Mrs JP Wilcock, a son Christopher, on 5 Oct 62.

12 DENT COYBirths

To Sgt and Mrs RK Jones, a daughter Shelley Lynn, born 28 Aug 62.

13 DENT COYBirths

To Capt and Mrs PJ Coulombe, a son, Marc Henri, born 26 Sep 62.

To Sgt and Mrs RB Innis, a daughter, Patricia Nora, born 8 Apr 62.

To Sgt and Mrs HM McCurdie, a son, Ronald Stuart, born 23 Jul 62.

To Cpl and Mrs TW Thrasher, a daughter, Evelyn Mildred, born 2 Jul 62.

To Cpl and Mrs WL Wylie, a daughter, Christina Susan, born 18 Sep 62.

Marriages

Capt RDH Bunt was married to Miss Marianne Grace Scheffield at Ottawa, Ont on 1 Sep 62.

Capt AB Perkin was married to Miss Heather Margaret Andrews at Toronto, Ont on 6 Oct 62.

13 DENT COY (cont'd)Hospital

Cpl WR Dawson - 18 - 30 Jul and 21 Aug - 4 Sep 62
 Cpl WL Wylie - 23 - 27 Jul 62
 Pte OR Sorensen - 21 - 29 Aug 62

14 DENT COYHospital

Capt JJPG Houle admitted to Shilo Military Hospital on 19 Aug 62
 and discharged on 24 Aug 62.

Sgt DM Hamilton admitted to Winnipeg Military Hospital on 21 Aug 62
 and discharged on 24 Aug 62.

15 DENT COYBirths

To Sgt and Mrs Tony Bourgeois, a son, Joseph Jean Bernard, born
 17 Jul 62.

Marriages

Cpl CVS Forsythe to Violet Marie Cox on 25 Aug 62 at Truro, NS.

LAW Dennis to LAC R Steeves on 27 Jul 62 at Goose Bay, Labrador.

Miss E Lapointe to Mr Benoit Villeneuve on 1 Sep 62 at Quebec City.

Hospital

Cpl JRM Chayer, Montreal Military Hospital - 28 Aug - 17 Oct 62

LAW Steeves, Goose Bay, 18 Sep - 25 Sep 62

Mrs I Johnston, 27 Aug - 15 Oct 62

4 FD DENT COYBirths

To Lt Col and Mrs Garth C Evans, a daughter, Marea, born at Iserlohn,
 Germany on 29 Jul 62.

To Capt and Mrs RH Headley, a daughter, Selena, born at Iserlohn,
 Germany on 1 Aug 62.

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DIRECTORATE OF DENTAL SERVICES NEWSAHQ Team Wins Canadian Army Rifle Championship

Pictured below is Major JC Brick receiving the Letson Trophy from the donor, Major-General HFG Letson, CB, CBE, MC, ED, CD, at Connaught Ranges, Ottawa. This trophy is presented annually to the team winning the Canadian Army Rifle Championship. Major Brick accepted, as Captain of the Army Headquarters (Adjutant-General) team, and will accompany the team next summer to Bisley, England where it will represent the Canadian Army. Major Brick is to be congratulated both as Captain of the winning team and for his personal achievement as a marksman.

DGDS Attends Annual Meeting of The RCDC Association

During the first week of October, Brig KM Baird and Col IAL Millar visited The RCDC School to interview candidates of the various courses in progress and also to participate in the opening ceremonies of the 14th Annual Meeting of the RCDC Association. During the Mess Dinner on the evening of 4 Oct 62 the Director General announced the winners of this year's awards in the General Efficiency Competition. Further details concerning the competition appear elsewhere in this issue.

Director General Presents RCDC Crest to US Naval Dental School

The presentation of a framed RCDC Crest for the US Naval Dental School, Bethesda, Md, was made by Brig Baird during a recent visit to Camp Borden and was accepted by Commander RR Troxell, USN (DC), exchange officer at The RCDC School. Other officers in attendance at this ceremony are pictured below:



L to R: G/C IH Barclay, Commanding Officer, CFMSTC, Capt DG Cartwright, Colonel IAL Millar, Lt Col WR Thompson, Major JM Smith, Major JJN Wright, Colonel CE Purdy, Commandant, The RCDC School and Major PS Sills

Lt Col SG Bagnall on Trip to Far North

Lt Col SG Bagnall was the RCDC representative on a recent RCCS inspection trip well inside the Arctic circle. In addition to providing dental treatment at Alert, he was able to liaise with the American detachment at Thule, Greenland.

Dental Officers Serve on University Staffs

Two officers of the RCDC are currently serving as part-time staff members of dental schools in Canada. Col AT Roger is lecturing in Oral Surgery at the Faculty of Dentistry, Dalhousie University for the second year. Assisting for the first time in the clinical program of the Faculty at the University of Manitoba is Major LA Richardson.

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THE RCDC SCHOOL NEWS

CGS Visits School

Lieutenant-General G Walsh, CBE, DSO, CD, Chief of the General Staff visited The RCDC School on 15 Aug 62. Following discussions with the Commandant the CGS toured the school and observed Phase 3 officer cadets undergoing clinical indoctrination.

Lt Col Thompson Presents Clinic at EODA Meeting

Lt Col WR Thompson, instructor in Oral Surgery at The RCDC School presented a clinic entitled "Complications in Exodontia and Minor Oral Surgery" at the annual convention of the Eastern Ontario Dental Association held in Ottawa 23 - 25 Sep 62.

Capt Casterton Returns to Duty

Capt CA Casterton's many friends will be pleased to learn that he returned to duty after a long illness. He was in Toronto Military Hospital from 21 Jun till 14 Sep and after sick leave returned to duty on 9 Oct 62.

WO2 Jones Retires

On 11 Sep the staff of the School gathered in the Common Room to bid farewell to WO2 Jack Jones who is retiring from the Corps after more than 23 years' service. Following an appropriate address, Col Purdy presented WO2 Jones with a decanter set on behalf of the staff.

RCDC Ladies on Project for Church

The wives of RCDC personnel, Camp Borden, are busily engaged in a project to raise funds which will be used to purchase a stained glass window (RCDC crest) for the Protestant Chapel. There are, at present, stained glass crests of several other Corps in place in the chapel and the ladies are to be commended for their efforts in this direction.

School Staff Members Aid in Search for Drowning Victim

It is not often that RCDC personnel become involved in aid to civil power activities and when it does occur, it is certainly newsworthy. The case in point highlights the alertness and willingness of three NCOs of The RCDC School staff.

WO2 HC Bilbey and Cpl H Chamberlain, two constant fishing companions, noticed, while fishing, a car upside down in the middle of the Nottawasaga River near Camp Borden. Most people will admit that finding a car in a river is no great feat but in this case the vehicle was amongst a graveyard of old cars. In any event they notified the local farmer who assured WO2 Bilbey and Cpl Chamberlain that he was not the owner and the police were alerted. The police had the car removed and discovered that the woman who was driving it had been missing for a couple of days.

Cpl WA Jackson, a member of the Aquateers of Canada, and three other club members were asked by the OPP and RCMP to search for the woman who was presumed drowned.

Due to heavy rains, the search was interrupted for several days and it was not until nine days after the woman was reported missing that the search

was able to be continued, except for surface patrols by the police. Cpl Jackson and the other three aquateers were then called back to carry out the underwater search and recovered the body in a log snag three hours later.

WO2 Bilbey and Cpl Chamberlain are to be commended for their alertness in reporting the out-of-place automobile and Cpl Jackson deserves much credit for his willingness to participate in a hazardous underwater search.

Distinguished Visitors

- 6 Sep 62 - Major General G Kitching, General Officer Commanding, Central Command.
- 7 Sep 62 - Members of the Permanent Joint Board on Defence.
- 4-5 Oct 62 - Brig KM Baird, Director General of Dental Services for the Canadian Forces and Col IAL Millar, Directorate of Dental Services, Army Headquarters.
- 4-5 Oct 62 - Brig HET Doucet, Deputy Adjutant-General, Army Headquarters.
- 10 Oct 62 - Major General AJ Clyne, Director General of Medical Services for the Australian Army.

Brigadier Wansbrough Presents Photograph

During his recent visit to the School, Brigadier EM Wansbrough presented a photograph of Camp Borden, as it appeared in 1916, to Col CE Purdy for inclusion in the RCDC School museum.

RCDC School Officers Host Local Dental Society

Members of the Muskoka and Simcoe Dental Association were guests of Col Purdy and the officers of The RCDC School for a meeting and dinner held on 17 Oct. Cdr RR Troxell, USN Dental Corps, Chief Instructor, presented an illustrated lecture entitled "Extensive Restorative Procedures Employing Simple Restorative Techniques" and Lt Col WR Thompson gave a presentation and film on "Oral Cancer". The dinner was held at the Headquarters Camp Borden Officers' Mess.

Sports

Cpl RS Walker was a member of the Camp Borden Soccer Team which participated in the Pearkes Trophy playoffs held in Victoria. He also played for the CFMSTC "Combines" who won the soccer championship in the Central Command Olympics at Kingston.

Capt A Van Ryssel successfully defended The RCDC School golf championship and retained the Fletcher Trophy.

A team of golfers from The RCDC School were runners-up for the Tuffy Tieman Trophy which is awarded for annual competition between CFMS and RCDC personnel in Central Command. School personnel participating were: Lt Col WR Thompson, Maj JJN Wright, Capt A Van Ryssel, Capt WB Hudgins, WO2 TL Batten and Cpl WA Jackson.

The three very ardent fishermen amongst the school staff have been reporting excellent catches. WO2 Bilbey has a six and one half pounder to his credit, Cpl Chamberlain a seven pounder but WO2 Ponton got the big one - a nine pound Rainbow Trout.

RCDC Crest Arrives at Bethesda

Lt Col JW Turner, instructor in Operative Dentistry at the School and currently on an exchange posting at the US Naval Dental School, Bethesda, Md is pictured below with Capt AR Frechette, Commanding Officer of the Naval Dental School. These officers are holding the mounted RCDC Crest which was presented to our sister service in recognition of the close ties which exist between the two Dental Corps.



NO 1 DENTAL EQUIPMENT DEPOT NEWSSports

Major Fletcher and Lt Kostyniuk are carrying on where they left off last year in the bowling league with averages of 242 and 243 respectively.

Miscellaneous

WO1 Morris was awarded various prizes for his garden efforts at the Camp Fall Fair this year.

Clarence Bolt, our cleaner at the Depot, is on the job as usual, even after drawing a horse in the Irish Sweep.

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11 DENT COY NEWS

As usual, a large number of postings took place during the summer months. We wish those who left continued success and welcome our new-comers.

Sporting Events

Now that the World Series is over the talk has turned to curling and the fever is rising by leaps and bounds.

Personnel of No 25 Dental Clinic, Griesbach Barracks, have been authorized to form a Pistol Team and hope to compete in championship matches.

Cpl Schuh (Boots) took part in a Black Powder Shoot sponsored by the Alberta Arms and Cartridge Collectors Association. He won first place in the Pistol Event using a 1900 Webley Pistol and 2nd place in the Military Rifle Event using a 1836 Mauser.

WO 2 Powers and fishing party made the headlines during August when they caught one of the largest octopuses ever caught in the Victoria Area. The newspaper report stated that it weighed 40 pounds, but Bill Powers says that it was closer to 80. Pictured below is the "catch".



L to R: Mrs. Nick Powers, Ron Powers, Bill Powers, Nick Powers

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12 DENT COY NEWSRetirement Parties

A farewell dinner was held in Stadacona Wardroom for Capt Frank Lovely prior to his release on the 26th August. Frank has accepted a full-time teaching assignment in the Oral Surgery Department of the Dalhousie Faculty of Dentistry and next year will be enrolled for three years post-graduate training at an American University.

A second farewell party was held in honour of Sgt Bill Fougere who is retiring early in November after serving with the Corps for more than seventeen years. A great many of his friends both in and out of the Corps were on hand to wish him well as he returns to civilian life.

Rescue at Sea

Major ED McDermott, Principal Dental Officer aboard HMCS Bonaventure for her current European cruise, had an unscheduled experience when the ship participated in rescue operations in connection with the crash of an American aircraft over the mid-Atlantic. It will be of interest to our more senior members that the Principal Medical Officer aboard HMCS Bonaventure, W/C DO Coons, is the son of Colonel Dwight S Coons, a former Director of our Corps.

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13 DENT COY NEWSNew Member of the Corps Receives Award

Colonel AC Leman congratulates Pte TR O'Mara (see photo below) on receiving an award from the DND Suggestion and Awards Committee. Pte O'Mara received the award and a cheque for his suggestion concerning the mounting of a .30 Caliber Browning A4 machine gun mount on a Ferret Scout Car. Formerly with RCME in Europe, Pte O'Mara recently transferred to the RCDC and is currently undergoing training as a dental assistant at Trenton.



Duty Trips to Radar Sites

During September, Capt.DDR Girard and Sgt JRA deBlois proceeded on TD from RCAF 6 Repair Depot to RCAF Station Ramore to provide treatment at this Northern Ontario site and Capt AJJC Vachon and Cpl DB Loosley made one of their periodic trips from Camp Petawawa to RCAF Stations Falconbridge and Foymount.

On 26 Sep 62, Colonel AC Leman, Capt EW Gazo, Ssgt EMB Everett and Sgt W Olynyk flew via RCAF "Albatross" aircraft to Moosonee, Ont to inspect and provide dental **services** for RCAF personnel stationed at this site. Capt Gazo and Sgt Olynyk remained until 19 Oct 62 to provide further dental treatment.

Former Corps Officers Tour Europe

Dr CW McCrary, Part V Dental Officer at 7 PD London is currently on a seven-week holiday abroad. Dr WO Gardner a former Part V Dental Officer now employed on a per diem basis at RCAF Station Uplands is enjoying the sights of Europe along with a Square Dance tour group from the USA. He expects that the highlight of his tour will be to dance at the famous castle in Heidleberg, Germany.

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14 DENT COY NEWS

Sports

The RCDC Bowling League has commenced their season, and all teams will be in competition for the trophies held at this HQ.

Our ardent curlers are preparing for a full season in their new Curling **Rink** and will be out to **capture** the various trophies up for competition.

NCO Enrolled as Dental Student

Our best wishes for success are extended to Sgt KPH Buchholz who has been accepted in second year dentistry at the University of Manitoba.

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15 DENT COY NEWS

Commanding Officer Represents DGDS at Clinic

Lt Col JG Butler was the official Corps representative at the 37th Annual Fall Clinic of the Montreal Dental Club 29 - 31 Oct 62.

Retirements

On 28 Jul 62, Lt Col and Mrs AR Smith were given a farewell dinner and social evening at St Jean on the occasion of the Colonel's retirement. This event was attended by the officers and their wives from St Jean, St Hubert and the Montreal area. The Smiths left for Prince Edward Island for a brief period of leave before the Colonel commences his call out for continuing duty at RCAF Station Summerside.

A farewell retirement party was given for Sgt Blanke by members of No 9 Clinic and QM Staff at St Jean. We wish him good luck and happiness in civilian life.

Mrs Johanna Lecompte retired for medical reasons after long and faithful service as a Part V dental assistant at the HQ Quebec Command Clinic. We trust that she will enjoy improved health in the near future and hope that she will carry many happy memories of her association with the RCDC.

Sports

Golfing members at Coy HQ have been prime targets this season for the GOC who plays an excellent game of golf. They were not able to outplay him at the annual Seagram Trophy competition, however, Capt Harrison did outdrive all participants in the longest drive event.

Enthusiastic golfers at St Jean miss the competition of Capt Ben Parent since his posting to Goose Bay and have recently turned their talents to the bowling alleys. A combined clinic and QM team has been entered in the RCAF Station league.

Personnel at Goose Bay report that fishing wasn't too good this year, although Maj Fell was top fisherman, having made some good catches at different lakes.

Capt Roy of RCAF Station Parent augmented his meat ration by shooting his first moose.

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35 FD DENT UNIT NEWS

DDGDS Inspects 4 Wing Clinic at Baden Soellingen, Germany

Pictured during his recent inspection tour of the Unit, is the Deputy Director General of Dental Services, Col GB Shillington with the Commanding Officer, Lt Col LG Craigie, LAW DJ Hollins, Maj WH Harrington, LAW MHC Jaeger, Capt HK Meisner and Sgt A Fox.



Sports

HQ 1 Air Division RCAF held its first annual golf tournament at Luxembourg on 11 Sep, under the direction of Lt Col Craigie, Chairman of the Golf Committee. Twenty-seven holes of golf, followed by a banquet and presentation of prizes, concluded a highly successful day for the "divot-diggers".

4 FD DENT COY NEWS

Unit on Early Fall Manoeuvres

Headquarters of 4 Fd Dent Coy and four dental sub-sections participated in the concentration of 4 Cdn Inf Bde Gp at Soltau from 5 - 19 Sep 62. In October, one sub-section manned by Capt Shaw, WO2 Gourlay and Sgt Wilkinson provided dental treatment for the brigade during a tactical exercise with the British Army on the Rhine.

Colonel Shillington Visits Brigade

Colonel GB Shillington visited the 4 CIBG area as part of his European tour and inspected the Coy 11 - 13 Jul. He interviewed all RCDC personnel and visited the static clinics. He and Mrs Shillington were guests of honour at a cocktail and dinner party held in the HQ Officers' Mess on 12 Jul. The following day at the close of his inspection the Colonel was entertained by the Coy NCOs at Fort Chambly.

CBUME NEWS

Medals Parade

A Medals Parade was held on 30 July for the more recent members of the Detachment and UNEF Medals were presented to Capt Conrad, Sgt Dancer and Cpl Moran.

Trips and Visits

During the month of July, Capt Claude Arpin was fortunate enough to spend an enjoyable 14-day leave in Italy and Ssgt Earl Schell headed for the cool mountains at Beirut, Lebanon for seven days.

Sports and Recreation

Capt Conrad (RCDC) and Capt Wallace (RC Sigs) were the winners of the recent bridge tournament held by the Canadian Contingent. Their victory established the only Canadian "first" in any UNEF competition held so far and we are particularly proud that a member of the RCDC shares this honour.

As manager of the CBUME table tennis team, Major Kelland led his doubles team to the finals in the UNEF competition. The Canadians placed second to the first prize winners - the Swedish team.

The Canadian Contingent softball league got underway on 16th September. At the opening game our Capt Conrad was the outstanding first baseman on the combined HQ and Ordnance Coy team. Unfortunately, "Cepeda's understudy" fractured his third finger right hand during a practise game on 22nd September and had to retire from the club. There was however one compensation - Capt Conrad was granted a three-week leave in Canada while his finger was healing.

MILITIA IN THE NEWS

Announcement - General Efficiency Awards - 1962

No 60 Dental Unit, Canadian Army (Militia), with headquarters at Edmonton, Alberta, competing with militia dental units across Canada for general efficiency during training, is the winner of two major trophies for 1962.

Commanded by Lt-Col SG Geldart, No 60 Dental Unit received the Moore Trophy as the most efficient unit and the Saskatchewan Dental Association Memorial Trophy as the most improved unit during the training year.

No 61 Dental Unit, Vancouver, BC, commanded by Lt-Col PL Rondeau, was awarded the Trelford Trophy for placing second in general efficiency.

No 57 Dental Unit, Winnipeg, Man, commanded by Lt-Col MJ Snidal, received an honorable mention.

Selection of trophy winners is made following an annual inspection of all participating militia dental units by an officer from the office of the Director General of Dental Services, Army Headquarters, Ottawa.

Dr Stephen A Moore, London, Ont, first honorary lieutenant colonel of the Royal Canadian Dental Corps, donated the trophy bearing his name.

To perpetuate the name of Lt-Col WG Trelford, VD, who commanded No 1 Divisional Dental Company, Canadian Dental Corps, officers of the unit donated the Trelford Trophy to be presented to the militia unit standing second in general efficiency competition.

No 1 Divisional Dental Company, CDC, was the first dental unit to proceed overseas during the Second World War.

RCDC Association Annual Meeting

The fourteenth Annual Meeting of the Royal Canadian Dental Corps Association was held at The RCDC School during the period 5-6 Oct. This meeting was preceded by an executive meeting of the Association on 4 Oct. Those attending were as follows:

Executive

Honorary President	-	Brig	EM Wansbrough
Past President	-	Lt Col	NL Simon
President	-	Lt Col	JS Goodfellow
President-Elect	-	Lt Col	WG Campbell
1st Vice President	-	Lt Col	GL Ramsay
2nd Vice President	-	Lt Col	CE Woods
Secretary	-	Col	CB Climo

Advisory Staff

ADDS Eastern Command	-	Col	JE Merritt
ADDS Western Command	-	Col	TJ Cooke

Unit Representatives

50 Dent Unit	-	Lt Col	JE Hallett
51 Dent Unit	-	Lt Col	HF Bonnell
54 Dent Unit	-	Maj	CG Hunt
55 Dent Unit	-	Lt Col	AJ Harris
55 Dent Unit	-	Maj	JD McLean
56 Dent Unit	-	Lt Col	AZ Henry
57 Dent Unit	-	Lt Col	MJ Snidal
58 Dent Unit	-	Lt Col	A Mintz
60 Dent Unit	-	Lt Col	SG Geldart
60 Dent Unit	-	Maj	AC Thompson
61 Dent Unit	-	Lt Col	PL Rondeau

Guests

Col	JF Edgecombe	-	Colonel Commandant of the RCDC
Brig	HET Doucet	-	Deputy Adjutant-General
Col	IAL Millar	-	Directorate of Dental Services
Lt Col	WH Salter	-	Directorate of Militia and Cadets

The Annual RCDC Association Dinner was held at the Canadian Forces Medical Service Training Centre Officers' Mess on 4 Oct. Brig KM Baird, Col CE Purdy, the officers of the RCDC School, and officers on the Capt-Maj Qualifying Course attended as well as the Association members and their guests.

"Edgecombe Award" and "Hugh McLaren Memorial" to be Created

The RCDC Association has announced that Col JF Edgecombe, Colonel Commandant of the RCDC has donated funds for the "Edgecombe Award" to be offered annually to the Militia Unit judged to have done the most to promote the work of the RCDC Association during the year.

It was also announced that a suitably-engraved gavel, to be used at all future meetings, will be purchased in memory of the late Colonel Hugh R McLaren who, in addition to his long and active association with the RCDC Militia, served as Treasurer of the RCDC Association for many years.

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The ROYAL CANADIAN DENTAL CORPS *Quarterly*



THE ROYAL CANADIAN DENTAL CORPS ASSOCIATION

Brigadier E.M. Wansbrough, OBE, MM, ED, CD,
FICD, FACD

When officers of the RCDC are requested to support the above organization they may very well ask "What is this Association?" "What does it do?" and "What is its purpose?".

In order to answer these questions a brief history is in order, which it is hoped will help to explain the objectives as stated in the Association constitution, i.e., "To promote the efficiency and esprit-de-corps of the Royal Canadian Dental Corps and to co-operate with fellow members of the Conference of Defence Associations in the promotion of general efficiency of Canada's Defence Forces."

Prior to and during the Second World War, dental officers were eligible for membership in the Defence Medical Association. However dental officers who attended the annual meetings found that the agendas were filled with specific medical problems which did not apply to the Dental Corps since it had, long since, been a separate Corps. The suggestion was made that a dental division be constituted but this idea did not find favour with the Medicals and it was decided to establish a separate organization to be known as the Defence Dental Association. Ex-militia officers of the Arms and Services of the Canadian Army who served in the CDC during the Second World War knew full well how much these associations had contributed in the lean days of the Non-Permanent Active Militia and were keen to have such an Association.

During the summer of 1947 an organizing committee composed of Col DS Coons, Col LV Janes and Major HC Thompson, all of Hamilton, Ontario, was given the responsibility to submit an application for membership in the Conference of Defence Associations. This membership was granted and a letter was dispatched to all ex-CDC officers in Canada which set forth the aims and objects of the Association. A channel of communication with the Minister of National Defence and the Chief of the General Staff was established to permit direct replies from these officials on matters dealing with the resolutions endorsed at the annual meetings.

Initially, the Association's membership was composed solely of ex-officers of the wartime Canadian Dental Corps and branches were formed in several cities across Canada. However, with the authorization and formation of the RCDC(M) the emphasis shifted to these units and their problems. It was thought that the facilities of these units would serve as rallying points where all officers of the RCDC, CADC, RCDC(R) and RCDC(M) could meet from time to time to consider matters of general interest.

The first meeting of the Defence Dental Association was held in the Mount Royal Hotel, Montreal on Oct 29-30, 1948. The Executive consisted of:

Honorary President	- Brig FM Lott
President	- Col LV Janes
1st Vice President	- Col DS Coons
2nd Vice President	- Lt Col CL Strachan
3rd Vice President	- Lt Col LA Stirling
Secretary-Treasurer	- Major HC Thompson
Assistant Secretary-Treasurer	- Lt Col WH Smith

Since that time, meetings have been held annually, with Ottawa being chosen as the primary site. This arrangement permits many senior officers of the three Armed Services to attend the meetings with some regularity. Perusal of the minutes of these meetings indicates the variety and complexity of the subjects discussed. Many resolutions have been framed and forwarded to the Conference of Defence Associations. In 1952 one of these called for the change in the name of the organization to the Royal Canadian Dental Corps Association. One of the most worthwhile results of the meetings has been to provide an opportunity for the Commanding Officers of militia units to get together to discuss their common problems and to review their progress during the current year.

In common with so many other organizations there are ever present financial problems. Dependent to a great extent on the vagaries of an annual government grant and the energy and vigor of the Commanding Officers of units in collecting and forwarding the annual dues, the treasury has often been in a precarious state. However, due to the skilful manipulation and management of the treasurer, the late Col HR McLaren, the accounts were always paid.

Although the dispersal of the RCDC units from the Atlantic to the Pacific provides wide distribution and representation of the Corps in the Armed Services of Canada, this dispersal also produces many problems of a challenging nature. These problems can only be discussed and resolved through a face-to-face meeting and the annual meeting of the Association provides such a medium. Administration, training, recruitment, accommodation, standards and regulations for awards are subjects which appear regularly in the minutes and are the subject of careful thought and discussion.

It is, therefore, with the hope of welding together all these elements and diverse interests that the RCDC Association exists. The working executive this year, Lt Col WG Campbell - President, Col CB Climo - Secretary, and Col CE Woods - Treasurer, can only accomplish so much. They depend on the active interest and support of all officers (past and present) of the Royal Canadian Dental Corps for the continuing success of this most worthwhile organization.

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A ROOT CANAL FILLING TECHNIQUE USING NEWLY DESIGNED INSTRUMENTS AND SILVER POINTS

Major JJN Wright, DDS

Many different endodontic techniques^{1,2,3}, produce consistent results of excellent quality when carried out by specialists who have had years of experience. However, the "occasional endodontist" requires a technique which will give dependable results and which can be easily mastered by a dentist of average skill. As a result of work done by Ingle⁴ and presented before The Second International Conference on Endodontics held in Philadelphia in 1958, a new and standardized system of designating instruments and points has been introduced. These instruments and points are now available to dental officers and their uniform size and taper make it possible for the "occasional endodontist" to produce root canal fillings of high quality.

Numbering System

The new size numbers, unlike the old are not just arbitrary figures but denote the diameter of the instrument at a point where the cutting blade begins (near the tip point D1 Fig. 1). The sizes range from 10 to 100 and express this diameter in tenths of millimeters.

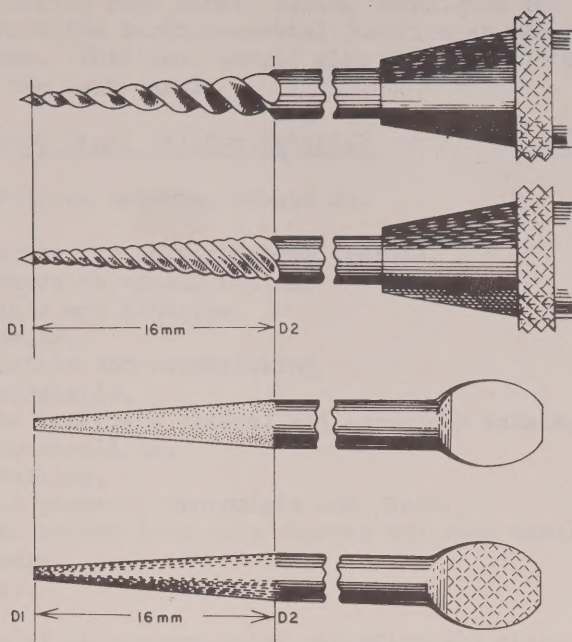


Fig. 11

A number 10 instrument or point for example is 10/100 or 0.1 mm in diameter at D1 while a number 25 is 0.25 mm.

Sixteen millimeters up the shaft from the point D1 is a point designated D2 which is 0.3 mm larger in diameter than D1 and thus provides a uniform taper for all sizes. Silver points, which are identical to the cutting instruments in number, taper and increment can thus be selected in the correct size without resorting to the "trial and error" method.

The following is an approximate comparison of the old and new number systems according to size:

<u>Old</u>	<u>New</u>	<u>Old</u>	<u>New</u>	<u>Old</u>	<u>New</u>
0	10	-	35	7	60
1	15	5	40	8	70
2	20	-	45	9	80
3	25	6	50	10	90
4	30	-	55		

The use of these new instruments and points thus makes it possible to obtain consistently well-prepared canals and accurately adapted silver points, with a considerable saving in operating time during the fitting stage.

Objective of Endodontic Technique

When considering root canal filling techniques the objective is to obtain a hermetic seal from the dentinocemental junction at the root apex to the floor of the pulp chamber. This seal should also obturate all accessory and lateral ramifications of the root canal.

Requirements of Root Canal Filling Material

An ideal filling material should be:

1. Non-irritating to periapical tissues.
2. Impervious to tissue fluids.
3. Adaptable and adhesive.
4. Radiopaque.
5. Nonvolatile and nonshrinking.
6. Bacteriostatic.
7. Able to penetrate lateral and accessory canals.
8. Easy to sterilize.
9. Non-staining.
10. Easy to prepare, manipulate and place.
11. Easy to remove from pulp chamber and root canal if necessary.
12. Stable.

There is no material at present which satisfies all these requirements. However, a technique of lateral condensation of gutta percha in combination with a fitted master silver point and sealer comes very close to the ideal. The method of lateral condensation of gutta percha alone can produce excellent results. However, even in the hands of the most competent endodontists there is always the danger of over-filling due to elongation of the gutta percha cones under the pressure of condensation.

Silver cones with sealer are ideal for fine canals, but in the larger canals such as are found in the maxillary anteriors, silver cones alone do not satisfy many of the requirements stated previously. In particular, their slight taper is likely to fit snugly for only a few millimeters in the apex of the canal.

A technique in which the master point is a standardized silver point fitted in a canal prepared by standardized instruments and in which the remainder of the canal is filled by the lateral condensation of gutta percha cones is a method which can easily be mastered by any dentist. This technique combines the advantages of both materials. The silver point can be placed precisely where desired in relation to the apex, fitting snugly in the apical area where it "corks" the foramen and prevents over-filling with the condensed gutta percha.

Silver points have the following advantages when used as master points:

1. They are manufactured to correspond to the size and taper of the cutting instruments.
2. They are rigid enough to be inserted into the canal with considerable force.
3. They follow curved canals readily.
4. They are easily sterilized by flaming.
5. They do not elongate during lateral condensation procedures.

Technique for Filling Large Canals with Closed Apices (Maxillary Anteriors)

The canal must first be adequately prepared and biomechanically cleansed to the dentinocemental junction at the root apex before it is ready for filling. In this regard the apical portion of the canal must be enlarged by the file or reamer to ensure complete obliteration by the silver point.

1. The tooth is isolated with a rubber dam and all surfaces around the crown disinfected with untinted tincture of metaphen or a similar disinfectant.
2. The previously prepared tooth is opened using an aseptic procedure, the medicated paper point is removed and the canal is irrigated with sodium hypochlorite.
3. The largest file used in the preparation of the canal is fitted with a rubber stop at a predetermined length (corrected working distance) and the walls of the canal are cleansed of any exudate which may have seeped into the canal.
4. A silver point of the same size as the instrument used in 3 above is selected (usually a #50 for maxillary anteriors). The point is grasped by a pair of hemostats at the predetermined length and sterilized by flaming.
5. The silver point is inserted into the canal until the hemostat touches the incisal edge. (The incisal edge is used as the visual landmark in determining the canal length). The silver point must fit snugly in the apical part of the canal. If the fit is not tight enough a small portion can be cut from the apical end of the point until a snug fit is obtained.

Note: If the preparation terminates at the root apex the point needs no shaping at the apical end. However, if the preparation terminates short of the root apex (the dentinocemental junction) the point must be sharpened with a sandpaper disk to correspond to the point on the reamer or file used in the preparation of the canal.

6. After fitting, the point is cut even with the incisal edge and a radiograph taken to verify its position. (Fig. 2 #1).

Note: While the radiograph is being processed, fine gutta percha points are transferred from a bath of untinted tincture of metaphen and placed between the folds of a sterile towel on the bracket table ready for lateral condensation. A sterile Kerr #3 spreader is also placed between the folds of the sterile towel.

7. The canal is dried with sterile paper points.
8. If the radiograph confirms an accurate fit, the silver point is notched half way through at the level of the gingival attachment.
9. The sealer is mixed as directed by the manufacturer and the apical **half** of the silver point is coated with the sealer and inserted into the canal until the tip is even with the incisal edge (Fig. 2 #1).

10. A sterile Kerr #3 spreader is inserted beside the master point and forced up by rotating the spreader back and forth while constant apical pressure is maintained (Fig. 2 #2).
11. A fine gutta percha point is picked up with a pair of cotton pliers in the right hand and held ready. The spreader is removed with the left hand and the fine gutta percha cone is inserted immediately into the pathway created by the spreader (Fig. 2 #3). This operation is repeated until no further points can be inserted into the mass (Fig. 2 #4). It should be noted that the spreader is always inserted on the same side of the master point.

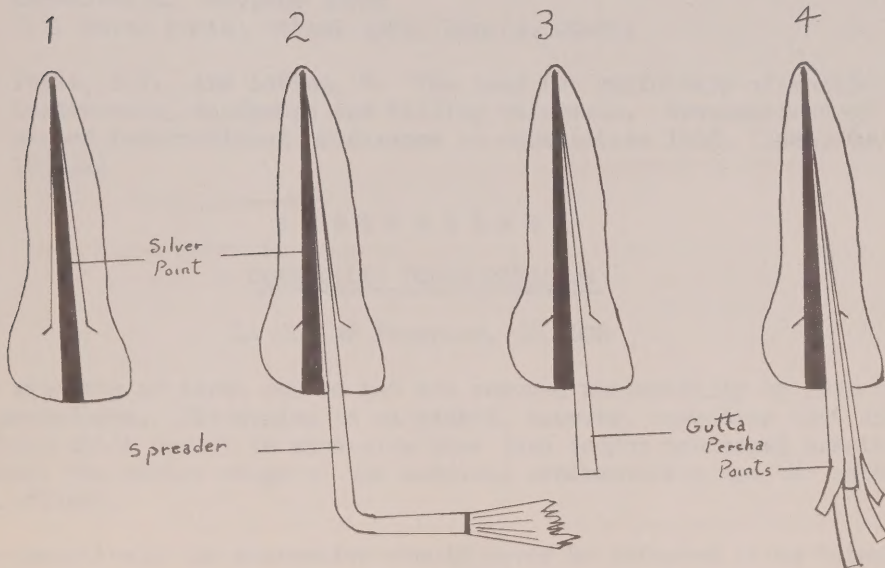


Fig. 2

12. A radiograph is taken to check the density of the filling.
13. If the filling is satisfactory, the gutta percha is removed from the coronal portion of the pulp chamber with a heated instrument. The portion of the silver point above the previously prepared notch is now removed by wiggling it back and forth until it breaks. All traces of sealer and gutta percha must be removed from the coronal portion of the pulp chamber to prevent future discoloration. The chamber is swabbed with chloroform and dried.
14. A temporary seal or a permanent filling is placed in the pulp chamber. A translucent material such as silicate or acrylic should be used as a permanent filling material. A substance such as crown and bridge cement should not be used as it will reduce the translucency of the crown and produce a dull appearance.

Summary

The new numbering system used for the endodontic cutting instruments and silver points recently added to the RCDC Stores List has been explained and the advantages of standardizing their size, increment and taper have been noted. A technique for filling large root canals which have closed apices has also been described.

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CONTROLLED TOOTH DIVISION

Lt Col WR Thompson, CD, DDS

The majority of teeth can be and are removed uneventfully by conventional exodontic procedures. Discussion is warranted, however, regarding that minority of extractions which result in excessive bone loss and/or prolonged sessions involving almost the entire range of the surgical armamentarium and the patience of the dental officer.

Pre-operatively the extraction should never be referred to as "simple". Every tooth with its supporting structures differs and many fractures of the root, crown and alveolar bone are impossible to predict or prevent. Other fractures, however, could be avoided by a more thorough pre-operative clinical examination, radiographic study and surgical plan. These factors are necessarily considered to some extent prior to every extraction but consideration must determine not merely that a tooth must be extracted but how it should be extracted.

The majority of surgical complications arise during the extraction of multi-rooted teeth and in these cases, "controlled tooth division" should be considered. This term refers to the division of the tooth by bur or chisel as a planned procedure to ensure an unimpeded path of removal with minimal bone loss. This procedure overcomes the tendency to apply excessive force, maintains better control and thus reduces the incidence of surgical complications.

INDICATIONS

Clinical examination should include both intra and extra-oral considerations. Much may be ascertained from the extra-oral facial form of the patient. If the face is square and compact, the zygomatic process will probably be low, the lips thick

and inelastic and the masseter muscle well developed. Intra-orally the dental ridge will usually be short, the buccal vestibule limited, the bony margins thick and the tongue and sublingual tissues high in the floor of the mouth. These factors not only make an extraction more difficult by limiting access to the operative site but they suggest dense bone and a low, large sinus cavity. The longer facial forms present less formidable problems but surgical procedures may be complicated by thin alveolar bony support and long roots of the molar teeth.

In addition to these general clinical observations the specific tooth to be extracted must be studied clinically and radiographically. The variances which indicate closer scrutiny and consideration of tooth division in the surgical plan are as follows:

1. Molar teeth with widely divergent roots

If the overall mesio-distal measurement of the roots is noticeably greater than the width of the crown, extraction will probably be impossible without causing fracture to the root or bone. Sectioning of the tooth will retain this bone or keep its loss to a minimum.

2. Molar teeth with locked bone between the roots

The roots curve out to a wider area than the crown then turn sharply in, locking sufficient bone to prevent tooth removal without fracture. These teeth must be individually judged from experience as many with a small amount of locked bone can be removed without complication.

3. Molar teeth with extensive decay

Extensive decay often results in insufficient tooth structure for adequate application of the forceps. The resultant slipping from the tooth could be extremely disconcerting to a patient and exasperating to a dental officer. The problem should be explained to the patient and the tooth sectioned initially.

4. Isolated teeth in the posterior region of the maxillary arch

Tuberosity fracture may result during posterior extractions, especially in older patients. Heavy occlusal stress over long periods causes the bone around such teeth to become extremely dense and the periodontal membrane to become very thin. Tooth division in these cases may be indicated.

5. Multi-rooted teeth with root canal fillings and/or post crowns

Pulpless teeth are well known to fracture more readily with the application of force. Sectioning will eliminate this complication in most cases.

6. Teeth with a heavy buccal ridge of bone near the cemento-enamel junction

Unless these teeth are sectioned initially, a considerable portion of the buccal alveolar wall may fracture.

7. Maxillary cases in which the sinus floor extends deeply between the molar roots

A portion of the floor of the sinus will often be removed with the tooth unless sectioning is carried out.

8. Maxillary cases in which the sinus cavity extends into the tuberosity area

This extension hollows out and weakens the tuberosity. Sectioning will eliminate excessive pressure and thus avoid possible tuberosity fracture during the extraction of maxillary second and third molars.

9. Impacted Teeth

The majority of these teeth require sectioning to facilitate removal, to conserve alveolar bone and to prevent pressure on the mandibular canal.

10. Teeth with an abnormal number of roots

Normal force cannot be applied to most of these teeth without resulting in fracture.

11. Teeth requiring extraction where the mandible is small and thin

Sectioning may be required to prevent fracture of the mandible if the teeth are large, abnormal in shape and firmly embedded.

12. When the initial force applied to mandibular molars suggests possible dislocation or partial dislodgment of the condyle head

This may occur in spite of mandibular support during removal. Sectioning should be considered to prevent stretching of the ligaments or damage to the temporo-mandibular joint.

13. When the application of normal force fails to produce the expected movement

In these cases sectioning should be resorted to since excessive or uncontrolled force causes many fractures of the root, crown and alveolar bone.

It is not suggested in all instances listed above, that a flap be raised, bone removed and the tooth sectioned before removal. It is emphasized, however, that the tooth must be carefully assessed clinically, radiographically and often by the limited application of force to determine if controlled tooth division is indicated.

TECHNIQUE

It is not within the scope of this paper to outline a sectioning procedure for each type of impaction or abnormal situation. A procedure will be outlined, however, for a maxillary and mandibular molar tooth with widely divergent roots. With the exception of impacted teeth, the technique as described can generally be applied to other cases.

The following procedure is recommended when tooth division is undertaken for the removal of an upper molar:

1. A buccal flap is raised. When tissue and bone resorption has occurred a horizontal flap will suffice. This incorporates only the gingival tissues about the tooth to be extracted and those teeth immediately adjacent. If resorption has not occurred, a vertical incision may also be required to allow sufficient soft tissue retraction.
2. A small amount of buccal bone is removed to expose the area just below the cemento-enamel junction. This bone may be removed with bur or chisel.
3. The buccal roots are now separated from the crown and lingual root with a cross-cut fissure airotor bur. This mesio-distal horizontal cut is made across the buccal roots slightly apically from the cemento-enamel junction. The cut is angled slightly toward the root trifurcation to aid in division. The bur depth should be slightly less than the estimated thickness of the buccal roots. A straight, flat-bladed elevator will complete the fracture of the buccal roots from the crown and lingual root.
4. The crown and lingual root are now removed in one section by the use of forceps.
5. The remaining buccal roots are divided by making a vertical cut with the same airotor bur. The flat-bladed elevator may be required to complete this division.
6. The less divergent buccal root is now removed with narrow-beak anterior forceps or, dependent on the root curvature, by elevator pressure. The remaining root is similarly removed.
7. The bony margin is smoothed with a bone file before suturing.

If the maxillary crown is grossly involved with caries it may be necessary to cut off the entire crown. The three roots are then separated by vertical cuts with the bur and the sections removed as single rooted teeth.

When a lower molar tooth requires controlled division the following procedure is instituted:

1. The gingival tissue margin is separated from the offending tooth. A flap is seldom required.
2. The crown of the tooth is sectioned bucco-lingually with the airotor bur. The cut is initiated on the buccal surface of the crown and extended through the lingual. The bur is then applied in the centre of the crown and extended apically to the depth of the root bifurcation. The bur cut is then extended laterally from the bifurcation almost to the buccal and lingual bony walls.
3. A flat-bladed straight elevator will ensure that the tooth is separated to the bifurcation.
4. The separated sections are removed with lower anterior forceps as individual single-rooted teeth. The less divergent root is removed first.

5. The socket area is smoothed and closed in the conventional manner. Sutures are seldom required.

If the roots are extremely divergent or enclose a considerable amount of locked bone a flap will be required. A small amount of buccal alveolar bone is then removed and to facilitate root removal, the entire crown is separated from the roots. This division is made near the cemento-enamel junction to ensure sufficient root projection for forceps application. The individual roots are separated vertically and the bur cut extended to well below the bifurcation. This extension reduces the bony support and thus the resistance to root movement. The roots are now removed individually with forceps or elevators.

The airotor bur is preferred for controlling division because it cuts more quickly than conventional burs and the method is more familiar to dental officers than the chisel sectioning technique. Furthermore, the bur removal of a definite amount of tooth structure ensures space for movement.

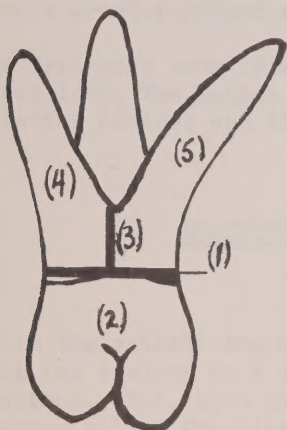


Fig. 1

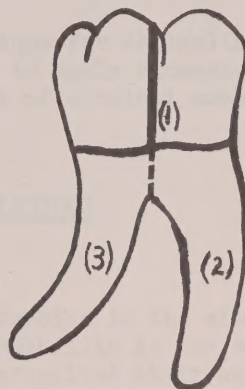


Fig. 2

CONTROLLED DIVISION AND EXTRACTION TECHNIQUES

Figure 1 - Maxillary Molar

- (1) Mesio-distal horizontal cut.
- (2) Crown and lingual root extracted.
- (3) Vertical cut between the buccal roots.
- (4) Less divergent buccal root extracted.
- (5) Remaining root removed.

Figure 2 - Mandibular Molar

- (1) Bucco-lingual cut through the crown and root trunk to the bifurcation.
- (2) Less divergent section extracted.
- (3) Remaining section extracted.

CONCLUSIONS

A planned procedure for controlled tooth division on indicated teeth will result in:

1. Preservation of important areas of osseous structure.
2. Avoidance of displacement of portions of teeth into adjacent structures such as the maxillary sinus.
3. Prevention of mandibular nerve injury.
4. Prevention of injury to adjacent teeth and their supporting structures.
5. Considerable saving in time.
6. Increased patient co-operation and confidence.

SUMMARY

Increased pre-operative emphasis, clinically and radiographically, on facial, oral and specific tooth variances will demand that tooth division be employed on a greater number of teeth.

The variances have been discussed and a technique for controlled tooth division outlined. The latter overcomes the tendency to apply excessive force, maintain better control and thus reduce the incidence of surgical complications.

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DIAGNOSIS OF THE "WHITE" ORAL LESIONS

Captain WB Hudgins, DDS

Since the establishment of dentistry as a profession in the mid-nineteenth century, it has evolved to a position of great responsibility in the health service professions. Yet, some practitioners have not recognized their obligation to accept responsibility for diagnosis of soft tissue lesions.

The dentist's working time and interests are concerned with the oral cavity. The patient in the dental chair is a captive subject. It is unreasonable and neglectful to miss an opportunity to recognize potentially dangerous lesions because they may be unrelated to immediate dental problems.

The following is an attempt to group together the white lesions of the oral cavity into the innocuous and those having possible serious implications.

1. INNOCUOUS WHITE LESIONS

a. White Sponge Nevus

This entity is most commonly found on the buccal mucosa where it presents a shiny white opalescent surface which may be filamentous in character. It is not a keratinized lesion, but the result of heaping of edematous epithelial cells which give it its spongy character. It is congenital, familial, and asymptomatic which facilitates its differential diagnosis.

b. Nicotinic Stomatitis

Found on the posterior palatal region where the mucosa presents elevated white keratinized areas surrounding blocked mucous glands. The causative factor is pipe smoking, which produces both heat and chemical irritation. It regresses with removal of cause.

c. Lichen Planus

The etiology of lichen planus is obscure but is associated with nervous tension. Clinically the oral lesions are white or yellowish-white lines in a lace-like pattern, although they may take the form of annular rings or plaques.

The sites affected in order of frequency are: the buccal mucous membranes, tongue, lips, hard palate and gingiva. The lesions are normally asymptomatic.

If diagnosis presents a problem, skin lesions are frequently found on flexor surfaces of the arms and legs. Normal tissue and lichen planus will stain with Lugal's solution (glycogen content) where keratotic lesions will not take up stain.

It occurs most frequently in the 30 - 40 age group and may be further differentiated from the leukoplakias, in that the margins are ill-defined and there is no change in tissue tone or flexibility.

d. White Hairy Tongue

A condition of unknown etiology in which elongation of the filiform papillae on the dorsal surface of the tongue is the dominant feature. Clinically this is rarely observed because of discolouration caused by secondary infection or exogenous pigments of smoking, food or medicaments.

e. Moniliasis (Thrush)

This fungus infection of *Monilia albicans* or *Candida albicans* may appear anywhere in the oral cavity as multiple grayish-white patches which can be peeled off leaving painful bleeding surfaces.

The infection occurs in either the very young or the old and debilitated, and therefore should be no problem in the intermediate age groups except where antibiotic therapy has upset the normal oral flora.

f. Fordyce Spots

Clinically this condition is exhibited in about 80% of the population beyond puberty. Yellowish-white, hypertrophied, sebaceous glands appear in clusters on the buccal mucosa at the level of the occlusal plane and may extend to the lips and retro-molar area. The granules are asymptomatic and of no known clinical significance.

g. Geographic Tongue

These lesions of unknown etiology are characterized by depressed red areas of desquamation surrounded by normal or hypertrophied filiform papillae, which appear white by comparison. The condition is found predominantly in the adult female and exhibits periods of remission and pattern changing which may require continual reassurance to the patient that it is harmless.

h. Burns - Chemical and Thermal

The typical picture of white coagulated protein presents no diagnostic problem. Questioning will normally elicit the causative agent such as aspirin, phenol, perborate, zinc chloride or the thermal agent.

2. WHITE LESIONS WITH SERIOUS IMPLICATIONS

The white lesions of the oral cavity represent a diverse group of diseases and reactions to injury. Oral cancer is more serious and more important to the patient than any other condition with which it might be confused. Therefore, the possibility of cancer should be eliminated first before treating on the basis of a benign lesion or waiting for further developments.

A great problem lies in the discrepancies between clinical and microscopic diagnoses compounded by confusion in the definition of leukoplakia.¹ An abbreviated list of terminology in use today includes:

- a. Pachyderma oris
- b. Leukoplakia (several grades)
- c. Carcinoma-in-situ
- d. Focal keratosis
- e. Asymptomatic cancer

Pachyderma oris and Focal keratosis are innocuous lesions but cannot be clinically differentiated from the others.

Clinically these lesions all may appear white, may be raised or flat, fissured or smooth, large or small, with well-defined borders. They predominate in males over forty years of age and present anywhere on the oral mucosa; the lips, tongue, cheeks and floor of mouth being most frequently involved.

Szerlip² says that one cannot differentiate on a purely clinical basis which white patch is a benign lesion, which is truly precancerous or which is frank malignancy. On this basis Robinson¹ has growing support^{3, 4} for using leukoplakia as a non-specific clinical term meaning only "white plaque" and carrying no implications of a precancerous condition.

A biopsy of all non-specific "white patch" or "leukoplakic areas" is essential if the dentist is to fulfil his responsibility in providing a complete and accurate diagnosis for his patients.

3. INDICATIONS FOR BIOPSY:

- a. When careful examination fails to lead to a diagnosis.
- b. Recognized precancerous lesion.
- c. Lesions which present clinical signs of malignancy:

- (1) Persistency
- (2) Progressiveness
- (3) Induration
- (4) Ulceration
- (5) Fixation of the base.

d. Lesions that fail to respond to recognized therapy.

SUMMARY

The clinical features of the white lesions of the oral cavity have been described.

The contention is held that clinical surface characteristics cannot be used to accurately predict the microscopic appearance of lesions; and that leukoplakia should be used as a non-specific clinical term.

A plea is made for increased use of biopsy service and its indications have been presented.

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A TRIP TO THE CONGO

Lt Col LG Craigie, CD, DDS

Most RCDC personnel look forward periodically to the time when they can get away from the office and do something different or go somewhere, if for no other reason than for a break in their daily routine. Because we are a comparatively small Corps and our role with the Canadian Forces necessitates that we concentrate with the larger military activity and formations which are not prone to move too far afield in peacetime, these interludes away from the office happen much too infrequently. Can you imagine the surprise you would feel if suddenly you received instructions to go to a far off place such as the Congo? This happened to me not too long ago when I received orders to visit the 57 Canadian Signal Unit in Leopoldville.

My schedule from my home station in Metz, France to Leopoldville in the Republic of the Congo looked something like this:

Lv Metz	-	1730 hrs	28 Oct 62
Ar Marville	-	1900 hrs	28 Oct 62
Lv Marville	-	0700 hrs	29 Oct 62
Ar Pisa	-	1500 hrs	29 Oct 62
Lv Pisa	-	0059 hrs	30 Oct 62
Ar Leopoldville	-	1100 hrs	30 Oct 62

You can see at a glance that the distance to be travelled is great - just add up the flying hours.

All Canadian soldiers posted to either Egypt or the Congo arrive direct from Canada at Pisa, Italy where they are divided into their separate groups. Those who are going on to Egypt take the North Star which arrives from Marville, France. The remainder, with the addition of other UN personnel, take the Yukon which came from Canada and proceed to the Congo. What a mixture of nationalities boarded the Yukon! To mention a few, there were military personnel from Austria, India, Denmark and Sweden and, believe it or not, a female secretary from Switzerland. We had a passenger list of some 73 people which included 18 soldiers who had just arrived from Canada.

On arrival, there was no doubt that most of us on board the Yukon had a misguided conception of the city of Leopoldville. Instead of the jungle that we had been viewing for better than two hours during the last leg of our journey, here was a modern airport with the second longest runway in the world. The air terminal building was modern in every respect, complete with a high terrace filled with people who were watching the activities below. Most of us had misjudged the climate too. We knew it would be hot but we were not prepared for such breathtaking heat, high humidity or the odour of wet vegetation. Little did we suspect then that within a few days we would be going about our tasks feeling and looking as cool as those who greeted us on our arrival.

Leopoldville itself is a beautiful city. Although the boulevards are overgrown with grass and some of the beautiful trees need trimming in certain sections of the town, the streets are wide and paved throughout. In fact a modern, lighted, four lane cross-town thoroughway divides the city. Ultra-modern apartment blocks can be seen everywhere and in a scenic section of the city running along the banks of the Congo river a surprisingly large number of embassies from all over the world are in operation. The local government and federal buildings are all of modern design. The most notable of these is an ultra-modern new Court of Justice building. Overlooking the city on one side is the Stanley Memorial while below is the mighty Congo River whose turbulent, muddy-gray waters seem to challenge one to proceed further. On the outskirts and in the hills is a modern university which boasts a newly-formed Faculty of Medicine.

Like many of our Canadian cities, Leopoldville too has problems. Since independence, the native population has more than trebled. No one really seems to know exactly, but the authorities estimate that over a million native Congolese have moved into the city, most of whom have come from the jungles, bringing with them their tribal customs and ways of life. Since housing and accommodation has not been able to keep up with this growth, most of the natives live in shacks or in very humble dwellings and these areas are indeed in sharp contrast to the luxurious surroundings of the better districts of the city. Employment is scarce and food is expensive but it is amazing how these people exist from day to day. The children seem happy and well cared for and the parents tidy and clean.

One custom which may appeal to some Canadian soldiers, and which may be food for thought to others, is that the Congolese women seem to do all the heavy and laborious work. It is quite common to see a housewife walking down the road with an overfilled basket balanced perfectly on her head and carrying a small child "piggy-back" fashion in a fold of her sarong-like dress. By switching her child from her back to her side while still in the fold of her dress, a good Congolese mother can feed her youngster without any interruption enroute to her destination or to the task at hand. The men, on the other hand, seem to prefer work that calls for the least amount of physical exertion and prefer to be employed

as cooks, laundry boys, houseboys or any other occupation that will keep them out of the hot sun. As in Europe, the outdoor cafe is popular and here the men gather in groups to discuss world or local issues or maybe just to watch the people pass by.

Directly across the Congo river from Leopoldville which is in the Republic of the Congo, lies a town called Brazzaville which is in the Congo. Both are independent countries. The former, before independence, was Belgian territory and the latter French territory. Some of you may recall that it was from Brazzaville that General Charles de Gaulle, now the President of France, directed the French Resistance Movement for a time. As a matter of fact, the house in which he lived and made his headquarters is now a well-marked tourist attraction. Here, life is much the same as in Leopoldville but one gets the impression that the way of life in general is more orderly and purposeful. The stores and shops are well stocked with imported goods and foods from France and the native population dress for the most part in European and American fashions.

Shopping in the Congolese ivory markets is entertainment at its very best. No prices are ever displayed and a purchase is made only after so much haggling that both parties are near exhaustion. Along with pieces of carved ivory, amber necklaces, paintings and wood carvings, a variety of animal and reptile skins can be bought. For amusement there are quite a few nightclubs in Leopoldville and the Congolese Nationals would like you to believe, and with some merit too, that "the twist" originated here. The Canadian soldiers also enjoy the luxury of a private swimming pool along with the comforts of their own messes and lounges.

Everyone wonders whether or not cannibalism is still practised in the Congo. Apparently it is in some regions and rumour has it that human meat is occasionally available at the markets in Leopoldville. Imagine asking in pidgin English for a tender leg of Alfonse "deboned" or "defemured"! or a pound of tender "trapezius"! Incidentally, one of our mess stewards, a wondrous fellow named Gabrielle, always kept insisting that even if the worst came to the worst in the Congo he wouldn't eat a Canadian officer. The reason for this is perhaps that Gabrielle prefers lean meat.

Even though my visit was short, it was an interesting and informative experience. In spite of the uncertain and tense political situation that exists at present in the Republic of the Congo, I couldn't help but feel envious of those Canadian servicemen who have such a golden opportunity to discover more about this wonderful country.

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Dental Treatment - Canadian Service Personnel in the Congo

Of the 301 Canadian personnel stationed in the Congo some 235 are located at Leopoldville. Lt Col Craigie's report on dental examination of 171 available personnel revealed that 90% were dentally fit. He further noted that some Canadian personnel acquired a rapid accumulation of calculus, primarily in the lower anterior region, along with a "brown stain" which was very difficult to remove. The etiology of the stain is unknown but it would appear the calculus formation and staining is of a local environmental nature rather than systemic.

(From a brief on the dental requirements and conditions of Canadian Service personnel serving in the Congo presented to DGDS by Lt Col LG Craigie.)

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WELCOME TO THE CORPS

A hearty welcome to the Corps is extended to the following personnel:

Gapt	JML	Rocheftort	-	to CJATC Rivers Manitoba
Pte	CS	Brown	-	to RCDC School
Pte	DE	Fraser	-	to RCDC School
Pte	DC	Hughes	-	to Vedder Crossing BC
Pte	JJ	Gallivan	-	to RCDC School
Pte	MD	Longford	-	to Camp Valcartier Que
Pte	JE	Silverson	-	to RCDC School
LAW	MN	Boles	-	to RCAF Stn St Jean
AW2	MOB	Cyr	-	to RCAF Stn St Jean
AW2	MM	Delory	-	to RCAF Stn St Hubert

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PROMOTIONS

Congratulations are offered to the following RCDC personnel on their recent promotions:

WO2	RG	Peebles	-	to Lt
Ssgt	EE	Mazerall	-	to WO2
Ssgt	RD	McHugh	-	to WO2
Sgt	SM	Toole	-	to Ssgt
Sgt	CA	Young	-	to Ssgt
Cpl	HK	Drawe	-	to Sgt
Cpl	CC	Millard	-	to Sgt
Cpl	DT	Moran	-	to Sgt
Pte	RA	Neill	-	to Cpl
Pte	A	Pink	-	to Cpl
Pte	CstC	Sabine-Paisley	-	to Cpl
Pte	RH	Stenabaugh	-	to Cpl

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RETIREMENTS

Another valued officer has retired from the Corps in the person of Lt EI Tullis of RCAF Stn Trenton.

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RELEASES

The following releases have become effective since the last issue:

Cpl	DAM	Fisher(RCAF)	-	35 Fd Dent Unit
Cpl	MLG	Larue	-	RCAF Stn St Hubert
LAW	MJ	Roberts	-	RCAF Stn Downsview
AW1	CM	Fraser	-	RCAF Stn Trenton
AW2	JM	Scott	-	RCAF Stn Trenton
Mrs	B	Villeneuve(Pt V)	-	Quebec City

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POSTINGS

The following movement of personnel has taken place recently:

Major	C	Brown	-	to FOB Winnipeg from 4 Fd Dent Coy
Major	IAC	MacDonald	-	to HQ NWHS Whitehorse from HQ Cal Grn
Major	SW	Muller	-	to HMCS Naden from HQ NWHS Whitehorse YT
Capt	MA	Abramson	-	to HMC Dockyard from HMCS Shearwater
Capt	EW	Gazo	-	to Camp Picton from RCAF Stn Trenton
Capt	WTH	Harley	-	to HQ Cal Grn from HMCS Naden Esquimalt BC
Capt	DJ	MacPhee	-	to HQ 4 CIBG from 1 RCR Fort York
Capt	LA	Reynolds	-	to RCAF Stn North Bay from RCAF Stn Clinton
Capt	WF	Shaw	-	to 1 RCR Fort York from HQ 4 CIBG
Capt	HC	Stewart	-	to FOB Winnipeg from RCAF Stn Saskatoon
Capt	DA	Warrick	-	to 7 PD London from Camp Ipperwash
WO2	EE	Mazerall	-	to HQ 13 Coy RCDC Trenton from D Pers RCDC
A/Ssgt	DT	Murley	-	to CBUME from HMCS Stadacona
Sgt	EL	Schell	-	to 12 Dent Coy from CBUME
Sgt	DLG	Flesher	-	to HMCS Stadacona from DGDS
Sgt	SG	Fraser	-	to HMCS Stadacona from HMCS Bonaventure
Sgt	RD	Innis	-	to RCAF Stn Goose Bay from RCAF Stn Uplands
Sgt	WS	Richardson	-	to RCDC School from RCAF Stn Goose Bay
Sgt	KJ	Smallshaw	-	to Pers RCDC from DGDS
Sgt	GH	Storms	-	to 11 Dent Coy from CBUME
Sgt	AJ	Tait	-	to QM Stores 11 Coy from 1 Dent Eqty Dep
Sgt	RJJ	Tremblay	-	to RCAF Stn North Bay from Camp Petawawa
Sgt	GW	Wilkinson	-	to 2 RHC Fort St Louis from Fort Chambly
Cpl	DL	Fenton	-	to RCAF Stn Winnipeg from RCAF Stn Saskatoon
Cpl	OW	Mandrusiak	-	to RCAF Stn North Bay from Camp Ipperwash
Cpl	A	Pink	-	to Ft Chambly 4 Fd Dent Coy from Camp Gagetown
Pte	CS	Brown	-	to HMCS Naden from HL RCDC(S)
Pte	N	Cable	-	to FOB Winnipeg from Fort Churchill
Pte	A	Girouard	-	to CFH Kingston from HL RCDC(S)
Pte	DW	Griffiths	-	to Edmonton from HL RCDC(S)
Pte	BF	Hannah	-	to FOB Winnipeg from HL RCDC(S)
Pte	RS	Lindsay	-	to 7 PD London from HL RCDC(S)
Pte	DF	Middleton	-	to Camp Gagetown from HL RCDC(S)
Pte	LH	Pion	-	to HMCS Stadacona from HL RCDC(S)
Pte	LA	Russell	-	to FOB Winnipeg from HL RCDC(S)
Pte	JH	Thorburn	-	to Camp Gagetown from HL RCDC(S)
LAW	JM	Giacobbo	-	to RCAF Stn Cold Lake from RCDC School
LAW	DA	Turner	-	to HQ 1 Air Div from RCAF Stn St Jean
AWL	MY	Smith	-	to RCAF Stn Rockcliffe from RCAF Stn Comox

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TRAINING

Corps personnel have attended the following courses:

University of Michigan, Ann Arbor, Michigan

Minor Oral Surgery - 26 Nov - 7 Dec 62 - Major TD Cobb
- Maj RJ Bryant

Complete Dentures - 7 Jan - 18 Jan 63 - Lt Col NA Butcher

TRAINING (cont'd)US Naval Dental School, Bethesda, Md

Partial Dentures - 7 Jan - 11 Jan 63 - Capt VM McMaster
 Oral Pathology - 14 Jan - 18 Jan 63 - Capt BA Gaudet

ENT Air Force Base, Colorado Springs, Col

Oral Surgery - 3 Dec - 14 Dec 62 - Maj EJC Small

Ohio State University, Columbus, Ohio

Oral Medicine - 21 Jan - 25 Jan 63 - Capt LA Reynolds

Civil Defence College, Arnprior, Ont

Emergency Health Ops - 10 Dec - 14 Dec 62 - Lt Col GR Covey
 and Adm

RCDC School CoursesDental Technician Clinical Group 4 - 13 Nov - 7 Dec 62

Ssgt	GEC	Bradley
Ssgt	MM	Fediuk
Ssgt	HEG	Franzgrote
Ssgt	JA	Fraser
Ssgt	R	Pelletier
Ssgt	JM	Tapp
Ssgt	JCA	Therrien
F/Sgt	DJ	Pierce

Dental Assistant Group 1 - 13 Nov - 14 Dec 62

Pte	RS	Black
Pte	HL	Boring
Pte	A	Girouard
Pte	JF	Giroux
Pte	GMR	Gravel
Pte	DW	Griffiths
Pte	BE	Hannah
Pte	DC	Hughes
Pte	HC	King
Pte	LPA	Lambert
Pte	RS	Lindsay
Pte	DF	Middleton
Pte	TR	O'Mara
Pte	LH	Pion
Pte	LA	Russell
Pte	RJ	Taillon
Pte	JH	Thorburn
AW2	RD	Armstrong
AW2	AM	Burdell
AW2	EL	Gunville
AW2	MA	Lawrence
AW2	SG	MacDonald
AW1	JE	Patterson
AW2	LF	Seraphim

1 Dental Equipment DepotDental Storeman Group 3 - 5 Nov - 30 Nov 62

Cpl	JG	MacPhee
Cpl	JA	Rochon

RCASC School, Camp BordenSenior NCO Course - 29 Oct - 21 Dec 62

Cpl	H	Chamberlain
Cpl	WR	Dawson
Cpl	WA	Jackson
Cpl	G	Sapergia

Office Management Course - 12 Nov - 7 Dec 62

Sgt	SH	Lunnin
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Command Junior NCO Courses

Cpl	TJ	Deloughery
Cpl	JAY	Ferland
Cpl	PD	Peterson

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VITAL STATISTICSDIRECTORATE

The Directorate staff are pleased to have Brig Baird return to the office after his recent hospitalization at Toronto Military.

RCDC SCHOOLBirths

To Capt and Mrs WB Hudgins, a son Craig Vernon, born 2 Dec 62.

Marriages

Pte HC King was married to Barbara Joan Maguire at Ottawa on 15 Dec 62.

Hospital

Capt CA Casterton returned to Toronto Military Hospital on 1 Nov 62 for three weeks with a recurrence of pneumonia.

Major WH Murray and Mrs Murray were admitted to Collingwood Hospital as a result of injuries sustained in an automobile accident.

WO2 Bruce Morse was admitted to Toronto Military Hospital on 14 Dec 62.

NO 1 DENT EQPT DEPHospital

Cpl RW McDonald and Pte H Snutch recently spent two weeks in hospital.

11 DENT COYBirths

To Capt and Mrs LC Gray, a son John Francis III, born 25 Oct 62

To Cpl and Mrs RA Neill, a son Wade Allen, born 1 Nov 62.

To Pte and Mrs TJ Herrett, a son Robert Bruce born 13 Nov 62.

Deaths

Miss FM Twyman, deceased 29 Nov 62.

12 DENT COYBirths

To Major and Mrs TC Gaudet, a daughter born 11 Nov 62.

To Capt and Mrs CD Mollins, a son born 8 Dec 62.

Hospital

WO2 GM Armstrong has returned to work following a two-month rest in hospital and sick leave.

13 DENT COYBirths

To Ssgt and Mrs JCA Therrien, a son, Pierre Bernard on 22 Sep 62.

To Capt and Mrs WJ Sinclair, a daughter, Holly Ann Lyn on 15 Oct 62.

Hospital

Major	AG	Andrews	- 4 Jan -
Sgt	AC	Vout	- 14 Jan - 17 Jan 63.
Sgt	JA	Gagnon	- 13 Dec - 19 Dec 62
Cpl	JEN	Boucher	- 15 Nov 62 -
Pte	RS	Lindsay	- 12 Oct - 18 Oct 62.

14 DENT COYBirths

To Capt and Mrs JJPG Houle, a son Joseph Jean Francois, born 23 Sep 62 at Camp Shilo, Man.

14 DENT COY (Cont'd)Hospital

Lt Col RB Jackson was admitted to Winnipeg Military Hospital on 26 Nov 62 and discharged the following day.

Capt JJPG Houle recently spent a month in Deer Lodge Hospital from 24 Sep to 21 Oct 62.

Sgt JRC Yeates was admitted to Deer Lodge twice recently and underwent surgery on his right knee. He was discharged finally on 23 Nov 62.

15 DENT COYBirths

To Cpl and Mrs Fret, a son Jeffrey John born 23 Dec 62.

Hospital

Sgt	EPH	Sprathoff	- 26 Oct - 13 Nov 62
Ssgt	GH	Couture	- 25 Oct - 31 Oct 62
Capt	JFA	Marcil	- 13 Dec - 18 Dec 62
Sgt	RG	Hopkins	- 8 Dec - 14 Dec 62

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DIRECTORATE NEWSCorps Conference

The 13th Annual Corps Conference was held in Ottawa from 3 - 5 December 1962 under the direction of Brigadier KM Baird. Senior officers of the Regular Force units in Canada gathered to consider various subjects related to the operation of the RCDC. Colonel GB Shillington chaired the formal meetings at which several papers were presented and open discussions held. The Commanding Officers later conferred individually with officers of the Directorate Staff on matters of particular concern to their units.

A Sunday evening reception for all Directorate and visiting officers held at the home of Col IAL Millar on 2 December and a formal supper dance on 4 December at the Army Headquarters Officers' Mess highlighted the social programme.

New Senior Appointment

Colonel JF Edgecombe, OBE, ED, CD, DDS, FICD, who has served as Honorary Colonel Commandant of the Corps since January 1960, was recently named Colonel Commandant of the RCDC. This new designation for the appointment is in accordance with current policy in the Canadian Army and gives recognition to the most valuable and loyal service that Col Edgecombe has rendered to the Corps for many years.

Christmas Party

A large representation of the servicemen and civilian personnel from the Directorate and 13 Coy Ottawa area clinics attended the Christmas Party at HMCS

Carleton on 14 Dec 62. WO2 Max Fisk expressed the appreciation of all personnel to the officers who acted as hosts and, in the absence of Brig Baird, Col Shillington responded and wished everyone a happy holiday season. Col Shillington also took this opportunity to make a small presentation on behalf of everyone present to Cpl Gene Lalonde who recently took his release after 20 years with the Corps.

Service Messes at Home on New Year's Day

The traditional tour of the various Officers' Messes in the Ottawa area was made by several officers of the Directorate following their attendance at the Governor General's Levee. Among the units to extend hospitality on this occasion was No 54 Dental Unit RCDC(M) and best wishes for the New Year were extended by the Commanding Officer, Lt Col HJ Chartrand on behalf of all ranks of his unit.

Brigadier's Secretary to Marry

Under ordinary circumstances, Directorate announcements of approaching weddings are not tinged with regret. However, the circumstances are not considered to be ordinary, to wit:

We announce joyfully (albeit regretfully) that Miss Patricia Veronica Curtin will be married to WO2 "Del" Riddell on February 2, 1963 at Blessed Sacrament Church, Ottawa. The groom-to-be is currently employed at RCAF Stn Trenton with 13 Dent Coy.

"Pat" has been a valued member of the Directorate since November 1942 and her transfer to the Department of Household Science and Domestic Tranquility will undeniably have an effect upon those of us who remain.

Over the years, Pat has toiled arduously on behalf of the Corps and whether her station was with Central Dental Stores, the Procurement Section or within the Office of the DGDS, her loyalty, knowledge, unfailing good humour and willingness to give that little extra effort has been evident.

We will miss "Pat", that's for sure, but wherever duty determines their domicile, we hope she knows that the best wishes of all Corps personnel will accompany both she and "Del", for a long life of everything that is good.

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THE RCDC SCHOOL NEWS

Exchange Officer Promoted

His many friends throughout the Corps will be pleased to hear that Cmdr RR Troxell, US Navy (DC), currently on an exchange posting and serving as Chief Instructor at The RCDC School, has received his promotion to the rank of Captain, effective 1 Jan 63.

Commandant and CI attend Corps Conference

Colonel CE Purdy, Commandant and Captain RR Troxell, Chief Instructor, journeyed to Ottawa in early December to attend the annual Corps Conference at which Colonel Purdy presented a paper entitled "The Dental Team Concept".

Maj Murray and WO2 Morse Injured in Traffic Accidents

Maj WH Murray, Senior Dental Officer, RCAF Station, Camp Borden was seriously injured in a three-car accident near Stayner, Ontario on 16 Dec 62. He was in his car being towed by another car which was struck by an oncoming vehicle. He suffered a broken pelvis and back injuries and is under treatment at Sunnybrook Hospital in Toronto. Mrs Murray who was riding in the tow vehicle was thrown through the windshield and received scalp lacerations and two fractured vertebrae. The driver of the tow vehicle was killed.

WO2 EB Morse was involved in a three-car pile-up a block from the School and received an injury to his left knee-cap which will necessitate a long period of hospitalization and rehabilitation.

Xmas Party

The officers of the RCDC School entertained the remainder of the school staff at a Christmas Party in the Common Room of the School on 20 Dec 62.

Maj Sills Big Winner

The CFMSTC Officers' Mess was the location for a mixed Mess Dinner followed by a Turkey Bingo on 7 Dec. Although nearly all of the RCDC School officers and their ladies were in attendance, the only winner was Maj Paul Sills. This, in itself, is not unusual but when he won two turkeys and narrowly missed on a third, perhaps it should be reported.

"The RCDC Toastmasters' Club is Now in Session!"

This phrase has followed the crack of a gavel every day of the week at The RCDC School since 14 Jan 63. It serves to open meetings of Public Speaking classes held daily for the candidates of the officers' clinic course and bi-weekly for the DT Cl Gp 3 course. The two classes are under the direction of Capt RR Troxell and Maj DH Protheroe, respectively.

The need for instruction in public speaking at the School has long been recognized and it was felt that a modification of the meeting format used by the Toastmasters' International organization, with which Capt Troxell was familiar, might meet the requirements. Basically this is a study group method for developing ability in public speaking.

The format was developed and introduced during the recent Technical Dental Therapist and DT Cl Gp 4 courses. It proved so popular and successful that it was decided to incorporate Toastmaster Club meetings into the 1963 course programme. The photograph (next page) shows members of the first RCDC Toastmasters' Club.

Perhaps the most unique and valuable feature of the Toastmasters' Club meetings is that each member participates in every meeting. This frequent practice rapidly develops the member's competence as a public speaker and increases his confidence and his ability to think on his feet. It is thrilling to watch a person change in a very short period of time from an apprehensive, knee-knocking, tie-straightening, stammering, suffering novice to a surprisingly accomplished, confident and articulate individual.

Considerable attention has been given to the physical surroundings and equipment. The conference room table, the podium, the gavel and stand, and the seating arrangements provide an appropriate atmosphere. One of the essentials

of a toastmasters' meeting is a timing mechanism to ensure that each participant performs his task within a specified period. This mechanism consists of a series of lights; green indicating the speaker may continue, amber showing there are thirty seconds remaining and red denoting overtime. The red light shines for thirty seconds after which a very loud bell sounds, making it impossible for the speaker to continue.



CHARTER MEMBERS OF THE RCDC TOASTMASTERS' CLUB

Clockwise from the Speaker FS Pierce DL are: WO2 Thorsson H, WO2 Daw RH, Ssgt Pelletier R, Ssgt Franzgrote HEG, Ssgt Fediuk MM, Ssgt Bradley GEC, WO2 Batten TL, WO2 Sherry JM, Ssgt Therrien JC, Ssgt Fraser JA, Ssgt Tapp JM, WO2 Lobb EM, and Major DH Protheroe. The President of the Club, Captain RR Troxell was away when this photograph was taken.

There are ten duties assigned for each toastmasters' meeting, three of which are permanently carried out by RCDC School staff; the remainder are rotated amongst the candidates. Perhaps the best way to describe these assignments is to relate the proceedings of a typical club meeting.

In the opinion of the writers Captain Troxell and Major Protheroe, the "Toastmasters' Club" is the most painless method available for developing ability in public speaking. The remarkable enthusiasm displayed by the candidates participating in the first class elicits the opinion that this subject will become a significant addition to the curriculum of the School.

RCDC SCHOOL RAISES FUNDS FOR CHAPEL WINDOW



Two of the projects which were undertaken by the staff of the RCDC School and their wives to raise funds for an RCDC window in Trinity Chapel are depicted above. A semblance of the proposed window is shown hanging on the wall of the RCDC booth at the annual chapel bazaar with Mrs CE Purdy and Mrs PS Sills offering for sale many of the attractive items which were designed and created by the ladies under Mrs RR Troxell's direction. Pictured on the right is Col CE Purdy watching Pte DE Fraser draw the winning ticket for the framed RCDC crest. Incidentally the crest was won by Cpl DT Gardner of the Directorate.

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NO 1 DENTAL EQUIPMENT DEPOT NEWS

Sports

Major Fletcher, Ssgt Sullivan, Ssgt Davison and Cpl Rochon all managed to win turkeys during the festive season. Competitive Bowling and Curling has its compensations for some.

Cpl McRoberts might be classed along with members of the Polar Bear Clubs as he has made two dives in the Ottawa River, 9 and 16 Dec 62 with other members of the Camp Petawawa Skin and Scuba Diving Club.

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11 DENT COY NEWS

Vancouver Paper Writes Sketch of Recent Corps Transfer

The following article has been extracted from a recent issue of the Vancouver Daily Province:

"A familiar figure with the United Nations Force in the Congo two years ago was a Canadian soldier who could be seen busily sketching the local inhabitants during his off duty hours.

He was Pte Denis C Hughes, a talented amateur portrait artist with soft pastel and oils and at that time a member of the Royal Canadian Army Service Corps.

Hughes, now serving with the Royal Canadian Dental Corps at Camp Chilliwack, spent eight months in The Congo in 1960.

His character portraits were so popular he gave most of them away to his subjects and returned to Canada with only a few sketches to show for his artistic efforts among the Congolese.

However, in addition to his pictures he brought back the memories of a close brush with danger when he and several other Canadians were trapped in the back of the post office at Leopoldville by Congolese who mistook them for Belgians.

Hughes and his comrades showed the Congolese their identification cards but none of the natives understood English. The Canadians eventually were saved by Congolese police.

His talent is well known at Camp Chilliwack where he has done a series of portraits of the officers who have served as Camp Commandants during recent years. The portraits were all drawn from photographs.

On some he had to draw in uniforms as the officers in question were in civilian clothes when their pictures were taken.

He started drawing as a boy in Portsmouth, England where he was born and lived until he was 17.

'I had no formal training' he said. 'Nothing more than I learned in school. It was mostly what I picked up over the years.'

He joined the British Army at 18 and served in France and Germany. He was demobilized in 1947 but re-enlisted in 1948 in the Royal Ordnance Corps as a driver instructor and served three years in Egypt.

He came to Canada in 1953 and served in the RCAF for three years, then joined the Canadian Army after a short spell as a civilian in Vancouver.

He's married and has two children, Ronny, 7, and Nancy, 6, who attend Watson Road Elementary School.

Hughes now hopes to turn his talents to sketching portraits of native Canadian Indians.

'They are people with interesting faces' he said. 'European faces are not bad but they don't have the character. The native people show their age in their features'."

Curling

With the curling fever reaching its peak, we are wondering whether Sgt Moore is talking to anyone now or not. His team had a perfect end at the Calgary Garrison Club on Dec 20th.

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12 DENT COY NEWS

"Doc" Left at the Dock

Arriving at a station to find that the train has already departed can be disquieting enough, but to return to dockside to discover that your ship has already sailed can create sheer panic. This happened to Capt Lachapelle and Cpl Bleakney who, along with 25 RCN officers and men, were left behind in Portsmouth, England when HMCS Bonaventure sailed earlier than scheduled. These personnel returned to Halifax aboard HMCS Nootka and earned their passage through participating in certain watch-keeping and message-centre duties.

Bowling

Congratulations are offered to the Gagetown Clinic bowlers who finished in fifth place with an average pinfall of 203 in the Command Bowling Tournament.

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13 DENT COY NEWS

Administrative Officer Retires

A farewell party was held on November 8th at Trenton in honour of Lt Ed Tullis on the eve of his departure to the Personnel Depot for retirement procedures. Colonel Leman presented Ed with an electric sander (to help smooth the road to civvy street?) on behalf of the RCDC personnel in the Trenton area. After 22 years with the Corps, Ed left with many memories mingled with a host of best wishes from us all.

Ipperwash Clinic Closes

The departure of 1 RCR on rotation to Europe reduced the treatment commitment at Camp Ipperwash to nil. The dental clinic will remain dormant until next summer at which time it will be re-opened for the Army Cadet Camp.

Duty Trips to Radar Sites

Capt JSE Doiron and Cpl JEN Boucher proceeded on a four-week TD trip to RCAF Station Falconbridge in mid-November. Unfortunately Cpl Boucher had to return to Petawawa on medical grounds before the tour was completed but Pte GED Hayes replaced him.

In December Capt JSE Doiron and Cpl WR Dawson went on a three-week TD trip to RCAF Station Foymount.

Capt EW Gazo and Pte TR O'Mara will be proceeding to RCAF Station Moosonee for a five-week TD trip commencing the end of January.

Long Service - Part V Dental Nurse

November marked the 12th consecutive year that Miss Florence Evans, Part V Dental Nurse, has served the RCDC in No 2 Clinic, RCAF Station Clinton.

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14 DENT COY NEWSCommanding Officer Heads Community Chest Campaign

Lt Col RB Jackson was appointed Chairman of the Winnipeg Garrison Community Chest Campaign which was conducted during Sep to Nov inclusive. The campaign was an unqualified success and went over the top one week before the target date. No 14 Dental Coy was the first unit in the Garrison to exceed its quota and receive the "Gold Feather Award".

Christmas Party

An enjoyable Christmas Party was held on 20 Dec 62 at RCAF Station Winnipeg with all RCDC and associated personnel in Winnipeg attending.

During the course of the evening the winners of the unit Bowling League "Turkey Roll" were awarded their prizes.

The evening was devoted to dancing and merry making after which a delicious buffet dinner was served.

Duty Trips and Visits

Lt HF Doyle visited No 7 Dental Clinic RCAF Station Saskatoon on 1 Oct 62 to check out Capt HC Stewart on closing of that clinic.

On 6 Nov 62, the CO No 14 Dental Coy and Administrative Officer, Capt GJ Moore visited RCAF Station Gypsumville, Man, a Radar Site under construction, to inspect dental facilities and obtain information as to build-up of personnel.

Curling

With the opening of the new Fort Osborne Curling Club, under the Presidency of Major Leon A Richardson, personnel of the Winnipeg Garrison have commenced the season activities with many of this unit participating. Plans have been completed to afford all curlers and neophytes of 14 Coy an opportunity to take part in the "roaring game" as an organized unit sport.

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15 DENT COY NEWSDental Officers Attend Montreal Fall Clinic

Lt Col Butler, Lt Col Anglin and Major Ramsay attended the Montreal Dental Club Fall Clinic 29 - 31 Oct 62. Many questions were asked and answers given regarding the DOSP and training conducted at the RCDC School. This interest was, no doubt, fostered by the RCDC exhibit and the military uniforms.

Holiday Season Activities

Christmas was the occasion of an excellent party held by RCDC members, wives and friends at RCAF Stn St Jean. New Year's Eve, of course, was the occasion for many more excellent parties whereat 1962 was drowned.

Duty Trips and Visits - Radar Sites

Lt Col Butler and Capt Jacob visited RCAF Stn Lac St Denis and RCAF Stn La Macaza 11 - 12 Oct to arrange treatment for personnel. Following this visit, Dr Jekyll and WO2 Stokes proceeded to RCAF Stn La Macaza to examine and categorize personnel. Using these priorities, patients will be transported to Lac St Denis for treatment.

Capt Sugars and Cpl Boulanger proceeded to RCAF Stn Moisie 5 - 30 Nov 62 to provide treatment at this isolated location.

Capt Jacob and Sgt Hopkins proceeded to RCAF Stn Chibougamau 28 Nov to arrange for installation of clinic equipment at this new radar site.

Sports

Curling, skiing and bowling are again prominent in the sports picture, and this year we have a Judo enthusiast in the person of Cpl Fret.

Major Guevremont, Ssgt Tapp, Cpl Jermain and Pte Thompson constitute the RCDC entry in the St Jean station bowling league and are vying for top position. WO2 Moore is currently the holder of the high average in the HQ Quebec Command league.

Lt Col Butler is setting the pace in this the first year of the HQ Quebec Command Curling League.

Capt Jean Vincent became the first and we trust, the only casualty of the ski season when, during the Christmas holiday, he suffered a twisted knee. Regular Army skiing is under the able direction of Capt Harrison.

The Winter Carnival and Quebec Command Sports Meet will be held at Camp Valcartier from 5 to 8 Mar 63. The above array of sportsmen indicates that the RCDC will be ably represented.

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4 FD DENT COY NEWS

Coy DOs Hold Seminar

The dental officers of the unit held a seminar on 14 Nov 62 under the chairmanship of Maj JVP Chatwin. One of the speakers, Capt RH Headley, recounted his impressions of the Capt to Major Qualifying course which he attended recently at The RCDC School.

Curling

A rink skipped by Capt Kelly won the third event in a Yuletide Bonspiel sponsored by the Fort York Curling Club. Two other rinks skipped by Lt Col Evans and Capt Shaw were eliminated while Maj Chatwin held on with his team and finished runner-up to Capt Kelly in the third event.

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35 FD DENT UNIT NEWSERR Carries out Unit Maintenance

L Sgt Posylyzny, DER from 4 Fd Dent Coy, toured the 1 Air Division clinics during the period 18 Oct to 9 Nov.

Dental Sub-section goes to England

Capt Turcotte, Sgt Marckwort and LAW Bigelow recently provided treatment for Canadian service personnel at 30 AMB Langar and CJS London.

Sports

Cpl WJ Parker coached the HQ 1 Air Division Flag Football Team to the 1 Air Division championship, completing the season undefeated.

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CEUME NEWSDetachment Holds Rotation Parties

On 10 Nov a Golf Tournament and "Rotation" party was held for Ssgt Earl Schell. The tournament was won by Sgt M Keill, RCAMC and the best dental score was turned in by Sgt (Glen) Storms. The evening party began with drinks and toasts to Earl Schell and later, the RCASC Sgt cook provided everyone with a delicious steak. In addition there were french fries, buns, salads, and a "special" cake suitably decorated for the guest of honour.

On 8 Dec a rotation party was held for Sgt (Glen) Storms. Since our previous combined Golf Tournament and social evening was so successful there was a repeat for Sgt Storms. Everyone was very happy to see Glen win the first prize at golf, especially as it was his rotation party. The RCASC cook with two Egyptian helpers prepared the foods which consisted of Southern fried chicken, french fries, salads, buns and cake.

Christmas in Jerusalem

During Nov Capt Bourget and L Sgt Dumas took a four-day Jerusalem tour. This tour was unique in that a Christmas carol service by both RC and Protestant Chaplains was held in Shepherd's Field, Jerusalem. The service was televised for presentation in Canada on Christmas Day and included a speech in French by Capt Bourget on his impressions of Jerusalem.

Dental Technician Visits Cyprus

Sgt G Dancer took a four-day tour to Cyprus in November. He found it to be an ideal place for a holiday. Meals and accommodation were moderately priced and many UK service installations are available on the island.

Leave Opportunities in Cairo

From 1 - 7 Dec 62 Sgt D Moran visited the leave centre in Cairo. While there he took all the tours available - Luxor, Alexandria, pyramids, tour of the city, and the Cairo museum. He considers this to have been his most interesting week since arriving here.

Defence Minister Inspects Detachment

On 8 Dec 62 the Minister of National Defence and Mrs Harkness inspected the Canadian Dental Detachment. Shown here is Mr Harkness inspecting the men's quarters with Colonel DH Rochester, Commander CBUME, and Major Kelland.



Medals Parade

A Canadian Dental Detachment parade was held on 10 Dec 62 at which UNEF medals were presented to Sgts Dumas and Fox.

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On 8 Dec 61 the President of the United States and the President of the United Kingdom met in London. This was the first time that the two heads of state had met since the end of the Second World War. The meeting was held at the Royal Albert Hall in London. The two presidents discussed the state of the world and the role of the United States and the United Kingdom in the world. The meeting was a success and the two presidents agreed to work together to maintain peace and stability in the world.



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